Maternal and Child Health Data Report

Washington State Department of Health
Maternal and Child Health Assessment

December 2003

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Chapters

Introduction

The Maternal and Child Health (MCH) Data Report is intended to be an ongoing report summarizing the various health indicators of the MCH population. The report is modeled after the Health of Washington State. The chapters are designed to be used individually as fact sheets or together.

This report will be an ongoing report on the status of MCH Priorities, which are reflected in the MCH Block Grant. The Health Resources and Services Administration (HRSA), the federal granting agency for the MCH Block Grant, requires annual reporting of State and National Performance Measures, Health Status Indicators, and Outcome Measures to track the health status of the MCH population. The first major use of this report will be for the upcoming Five Year Needs Assessment. Programs are now beginning to meet with stakeholder groups and the Data Report will be used in the discussions.

Sections of this report will be updated periodically as new data sets from Vital Statistics, Washington State Comprehensive Hospital Abstract Reporting System (CHARS), and Pregnancy Risk Assessment Monitoring System (PRAMS) become available. Planned new chapters include Mental Health, Family Violence, and Services for the MCH Population.

Staff in the Maternal and Child Health Assessment Section of the Washington State Department of Health prepared this report. Each chapter focuses on a topic relevant to the MCH population, and primarily relies on graphs and charts to provide a snapshot of how Washington State looks. Each chapter provides data that describe the MCH population and breaks the information down by county, age, gender, race and ethnicity, rural and urban residence, and Medicaid status where available. Yearly data from 1980 through 2001 have been included, when available, in order to observe trends. Additional information about the data sources is included in each chapter and the technical notes section.

Washington State Population and Birth Counts, 2001

County	WA Population [1]	Population 0-19 Years [1]	Women 15-17years [1]	Live Births [2]	Singleton Live Births [2]
State Total	5,974,900	1,694,106	127,157	79,542	77,242
Adams	16,600	6,173	451	328	316
Asotin	20,700	5,796	510	234	227
Benton	144,800	46,881	3,723	2,215	2,128
Chelan	67,100	20,523	1,554	971	941
Clallam	64,454	15,745	1,327	606	580
Clark	352,600	109,566	7,776	5,322	5,200
Columbia	4,100	1,070	94	35	35
Cowlitz	93,900	27,485	2,092	1,229	1,211
Douglas	32,800	10,547	836	440	430
Ferry	7,300	2,173	201	75	75
Franklin	50,400	19,055	1,338	1,147	1,127
Garfield	2,400	672	69	23	21
Grant	75,900	26,617	1,977	1,313	1,286
Grays Harbor	68,500	19,321	1,619	766	737
Island	72,400	20,032	1,442	897	879
Jefferson	26,446	5,633	501	200	192
King	1,758,300	436,986	31,638	21,778	21,081
Kitsap	233,400	68,262	5,278	2,946	2,869
Kittitas	34,000	8,918	620	371	357
Klickitat	19,300	5,641	470	221	216
Lewis	69,500	20,249	1,678	856	834
Lincoln	10,200	2,766	261	92	92
Mason	49,600	12,853	1,113	543	523
Okanogan	39,700	11,955	1,011	518	498
Pacific	21,000	4,940	420	203	196
Pend Oreille	11,800	3,339	321	124	120
Pierce	713,400	213,880	15,897	10,052	9,738
San Juan	14,400	2,953	234	104	100
Skagit	104,100	30,188	2,397	1,383	1,355
Skamania	9,900	2,869	250	109	109
Snohomish	618,600	184,551	13,622	8,703	8,455
Spokane	422,400	121,666	9,332	5,414	5,243
Stevens	40,300	12,481	1,154	449	437
Thurston	210,200	58,826	4,797	2,606	2,539
Wahkiakum	3,800	949	95	29	29
Walla Walla	55,200	15,898	1,213	714	696
Whatcom	170,600	47,857	3,526	1,965	1,915
Whitman	40,300	10,883	657	375	365
Yakima	224,500	77,906	5,664	4,186	4,090

[1] Office of Financial Management, Intercensal and Postcensal Estimates of County Population by Age and Sex: 1980-2003, November 2003

[2] Vital Registration System. Annual Statistical Files, Birth Certificate Data: Washington State Department of Health, Center for Health Statistics (CHS), 1980 -

Pregnancy Outcomes Washington State Residents, 1983 - 2002[3,4,5]

	Women	Pregnancy		Live Births		Abortions[6]		Fetal Deaths	
Year	15-44	Number	Rate	Number	Rate	Number	Rate	Number	Ratio
1983	1,029,732	95,827	93.1	68,794	66.8	26,560	25.8	473	6.9
1984	1,042,867	96,235	92.3	69,059	66.2	26,732	25.6	444	6.4
1985	1,061,003	96,595	91.0	70,357	66.3	25,835	24.3	403	5.7
1986	1,073,620	97,008	90.4	69,572	64.8	26,991	25.1	445	6.4
1987	1,087,409	99,887	91.9	70,409	64.7	29,067	26.7	411	5.8
1988	1,103,462	102,216	92.6	72,660	65.8	29,175	26.4	381	5.2
1989	1,123,340	106,435	95	75,595	67	30,452	27	388	5
1990	1,151,604	110,543	96.0	79,468	69.0	30,613	26.6	462	5.8
1991	1,183,653	110,778	93.6	79,962	67.6	30,390	25.7	426	5.3
1992*	1,197,928	109,267	91.2	79,897	66.7	28,922	24.1	448	5.6
1993*	1,215,051	107,971	88.9	78,771	64.8	28,804	23.7	396	5.0
1994*	1,227,406	105,141	85.7	77,368	63.0	27,330	22.3	443	5.7
1995*	1,243,506	104,309	83.9	77,240	62.1	26,650	21.4	419	5.4
1996	1,257,029	104,732	83.3	77,874	62.0	26,396	21.0	462	5.9
1997	1,271,209	105,653	83.1	78,141	61.5	27,055	21.3	457	5.8
1998	1,279,437	105,724	82.6	79,640	62.2	25,613	20.0	471	5.9
1999	1,285,708	106,010	82.5	79,577	61.9	25,965	20.2	468	5.9
2000	1,292,645	107,504	83.2	81,004	62.7	26,063	20.2	437	5.4
2001	1,299,176	105,958	81.6	79,542	61.2	25,998	20.0	418	5.3
2002	1,300,189	104,883	80.7	79,003	60.8	25,446	19.6	434	5.5

[3] Source: Center for Health Statistics, Washington State Department of Health, 10/2003. (http://www.doh.wa.gov/ehsphl/chs/chs-data/abortion/download/2002_AB.xls)

[4] 1990-2001 Population Estimates: EPE Unit, Public Health - Seattle & King County, June 2003.

[5] Rates equal total pregnancies, births, or abortions per 1,000 women of childbearing age (15-44). The fetal death ratio is equal to total fetal deaths per 1,000 live births.

[6] Abortions for 1992-1995 include 1,262; 1,234; 1,316; and 1,346 estimated abortions that were not reported in original published reports.

Washington State Mortality By Year[7]

	Perinatal		Neonatal		Postneonatal		Infant		Child	
	Fetal plus 0-6 days		0-27 days		28-364 days		0-364 days		0-18 years	
	Number	Rate per 1,000 live births	Number	Rate per 1,000 live births	Number	Rate per 1,000 live births	Number	Rate per 1,000 live births	Number	Rate per 100,000 population
1980	na	na	482	7.1	320	4.7	802	11.8	1,407	115.9
1981	na	na	444	6.3	291	4.2	735	10.5	1,285	104.8
1982	na	na	431	6.2	324	4.7	755	10.8	1,277	104.4
1983	na	na	376	5.5	280	4.1	656	9.5	1,116	91.7
1984	na	na	374	5.4	328	4.8	702	10.2	1,210	99.4
1985	na	na	433	6.2	316	4.5	749	10.6	1,254	102.0
1986	na	na	375	5.4	301	4.3	676	9.7	1,181	95.5
1987	na	na	365	5.2	318	4.5	683	9.7	1,235	98.7
1988	na	na	335	4.6	321	4.4	656	9.0	1,187	93.3
1989	na	na	383	5.1	311	4.1	694	9.2	1,165	89.8
1990	na	na	333	4.2	289	3.6	622	7.8	1,099	82.5
1991	na	na	315	3.9	288	3.6	603	7.5	1,056	76.4
1992	667	8.3	291	3.6	249	3.1	540	6.8	984	69.2
1993	589	7.4	247	3.1	248	3.2	495	6.3	970	66.2
1994	651	8.4	275	3.6	203	2.6	478	6.2	976	65.2
1995	635	8.2	259	3.4	190	2.5	449	5.8	917	60.0
1996	704	9.0	292	3.8	175	2.3	467	6.0	912	58.7
1997	664	8.4	263	3.4	177	2.3	440	5.6	898	56.9
1998	692	8.6	285	3.6	167	2.1	452	5.7	998	62.5
1999	674	8.4	257	3.2	144	1.8	401	5.0	819	51.0
2000	628	7.7	248	3.1	175	2.1	423	5.2	824	51.5
2001	652	8.2	292	3.7	169	2.1	461	5.8	841	52.3
2002	657	8.3	287	3.6	165	2.1	452	5.7	853	53.0

[7] Source: Center for Health Statistics. Washington State Department of Health, 1980-2002

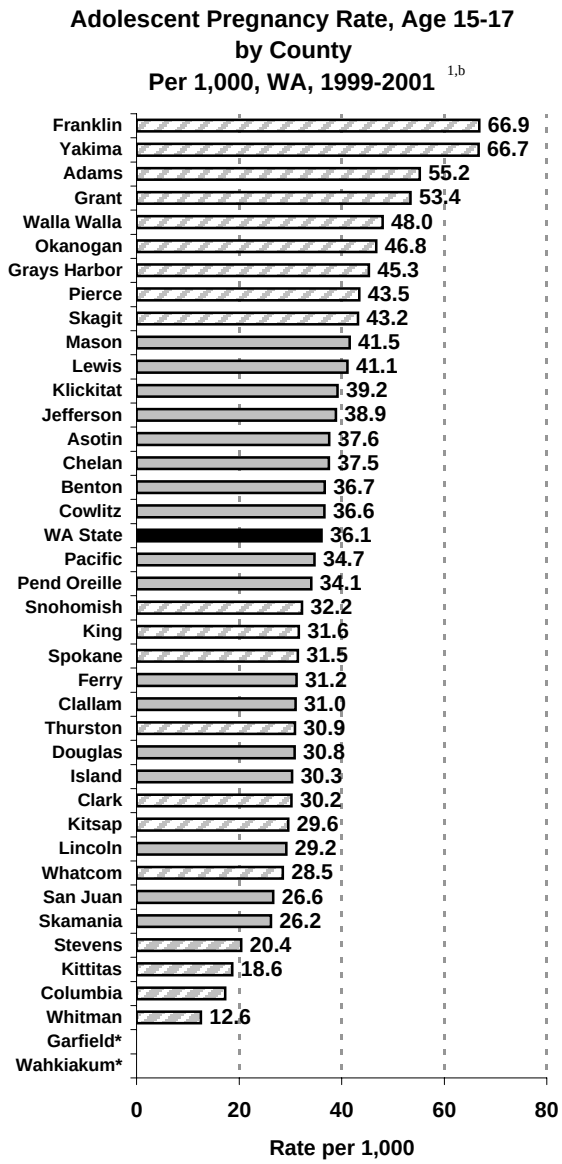
Adolescent Pregnancy

Definition: Adolescent pregnancies are estimated by adding together reported births, induced abortions, and fetal losses for women age 15-17.[a] Spontaneous abortions (miscarriages) occurring prior to 20 weeks gestation are not included because there is no way of accurately estimating their number.

Key Findings

- **Washington's adolescent pregnancy rate in 2001 was 32.9 per 1,000 women ages 15-17 years. This represented 4,183 pregnancies to women age 15-17. The most recent national rate available is the 1999 adolescent pregnancy rate of 55.9 per 1,000.[1,2]**
- **Washington's adolescent pregnancy rate decreased significantly from the 1990 rate of 57.9 per 1,000 women ages 15-17.[1,b]**
- **Approximately 54% of adolescent pregnancies resulted in live births for a total of 2,251 births in 2001.The Washington adolescent birth rate was 17.7 per 1,000 in 2001, compared to a national rate of 25.2 per 1,000 women ages 15-17.[1,2]**
- **Reliable data on adolescent abortions by race and ethnicity are not available, so race and ethnicity data from live births are presented here. Adolescent birth rates are significantly higher in Blacks and American Indian/ Alaska Natives compared to other racial groups while Hispanics have a significantly higher adolescent birth rate compared to non-Hispanic teens.[1,b]**
- **The Healthy People 2010 objective is for no more than 43 pregnancies per 1,000 women 15-17 years old .[3]**

County

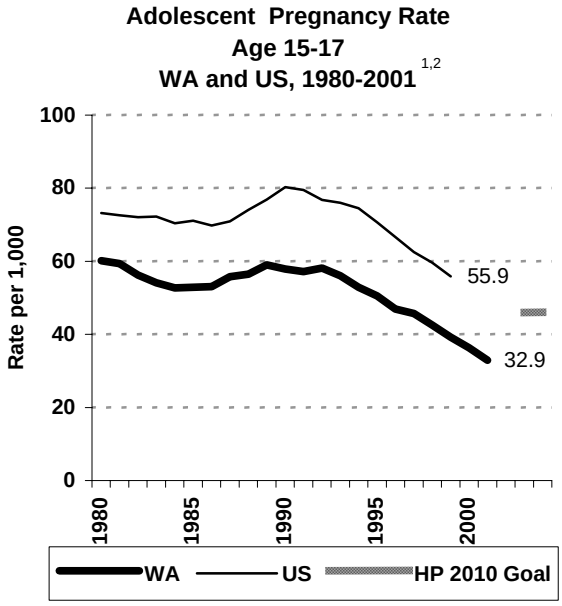


**Rate not calculated if less than 5 events.*

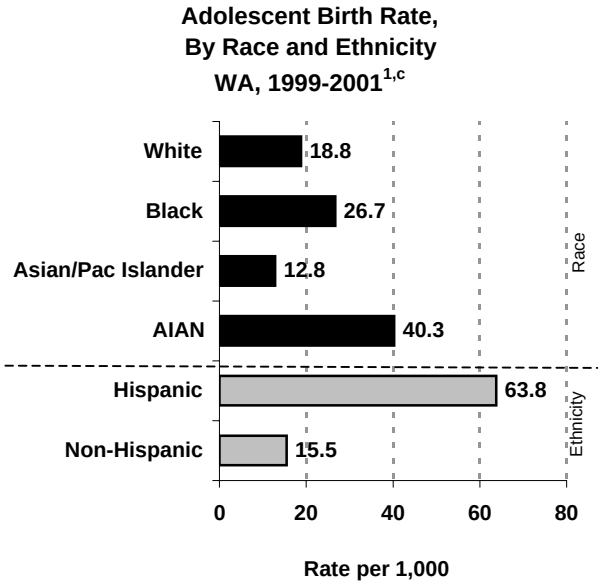
Significantly different from state rate

Adolescent Pregnancy (cont.)

Time Trend



Race and Ethnicity (Live Births)



Data Sources

[1] Washington State Pregnancy and Induced Abortion Statistics 2001. Washington State Department of Health, Center for Health Statistics.

[2] Births: Final data for 2001. National Vital Statistics Report; Vol 52 No 2. Hyattsville, Maryland: National Center for Health Statistics. 2002.

[3] Department of Health and Human Services (US). Healthy People 2010: Understanding and Improving Health. 2nd edition. Washington, DC: US Government Printing Office; November 2000.

Endnotes

[a] In this section, adolescents are 15-17 year olds unless otherwise indicated. Analysis was restricted to 15-17 year olds because they are school age. Pregnancy among women younger than 15 is a rare event and women older than 17 are at lower risk for poor birth outcomes.

[b] Significance is based on 95% Confidence Intervals.

[c] AIAN - American Indian Alaskan Native

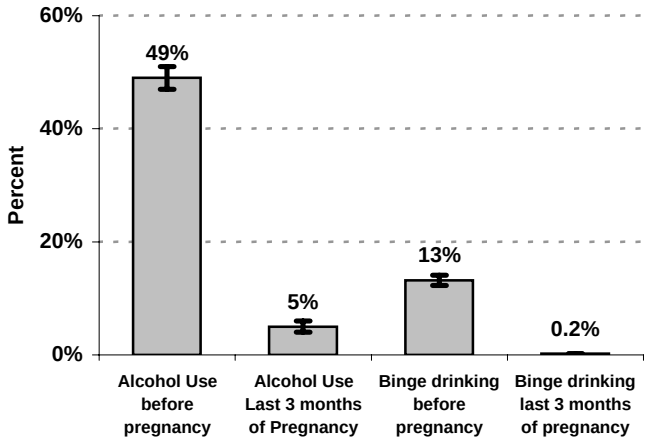
Alcohol Use During Pregnancy

Definition: Self-reported data from the 1998-2000 Pregnancy Risk Assessment Monitoring System (PRAMS) based on the average number of alcoholic drinks per week during the three months before the woman got pregnant and the last three months of their pregnancy. Alcohol use is defined as any drink of alcohol during the time in question while binge drinking was based on the woman responding that at least once she had 5 or more alcoholic drinks at one sitting.

Key Findings

- **Maternal prenatal alcohol exposure is one of the leading preventable causes of birth defects and developmental disabilities. Fetuses exposed to alcohol can develop a wide range of disorders from subtle effects of I.Q. to severe mental retardation. There is no safe amount of alcohol, nor a safe time, that a woman can drink while pregnant.**
- **From 1998 - 2000, an estimated 49% of new mothers reported drinking alcohol during the three months before becoming pregnant, and 5% reported drinking alcohol during their third trimester of pregnancy.[1]**
- **While the largest percentage (~56%) of pre-pregnancy drinkers were women ages 35 and older, about one-third of women who were under age 20 at childbirth reported drinking prior to pregnancy.[1]**
- **An estimated 13% of new mothers reported binge drinking during the 3 months before they got pregnant while less than 1% reported binge drinking the last 3 months of pregnancy.[1]**
- **Women who intended to become pregnant were significantly less likely to binge drink before they became pregnant than women who did not intend to become pregnant.[1,a]**
- **Asian mothers were significantly less likely to report drinking before pregnancy than other races. Hispanics were significantly less likely to report drinking before and during pregnancy than non-Hispanics.[1]**
- **Non-Medicaid women were significantly more likely to report drinking before pregnancy than Medicaid women or Grant Recipients.**
- **Women with four or more years of college education were the most likely to report drinking during 3rd trimester (~8%). There was no difference in reported binge drinking during the third trimester by mother's educational status. (Data not shown).[1,a]**
- **The Healthy People 2010 objective is for at least 94% of pregnant women to abstain from alcohol and 100% to abstain from binge drinking during pregnancy.[2]**

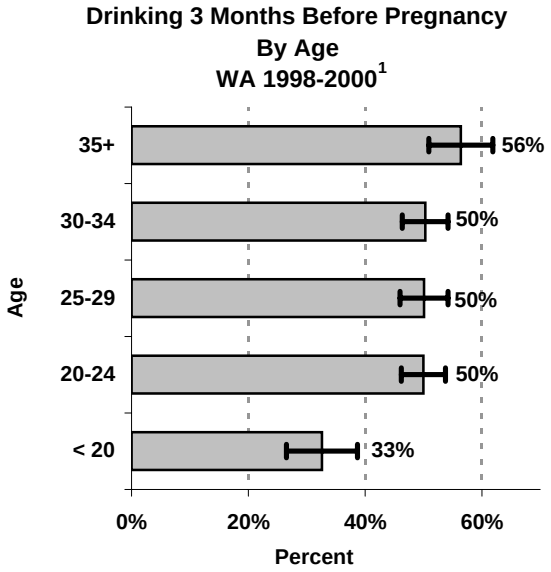
Alcohol Use Before and During Pregnancy
WA Prams 1998-2000[1]



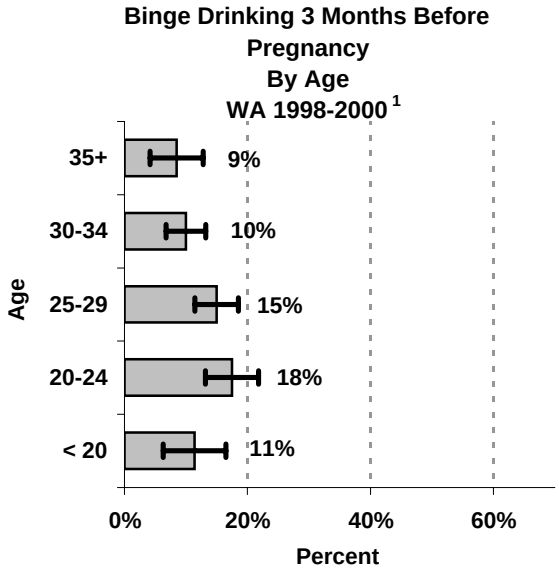
Alcohol Use During Pregnancy (cont.)

Alcohol Use in Pregnancy By Maternal Age

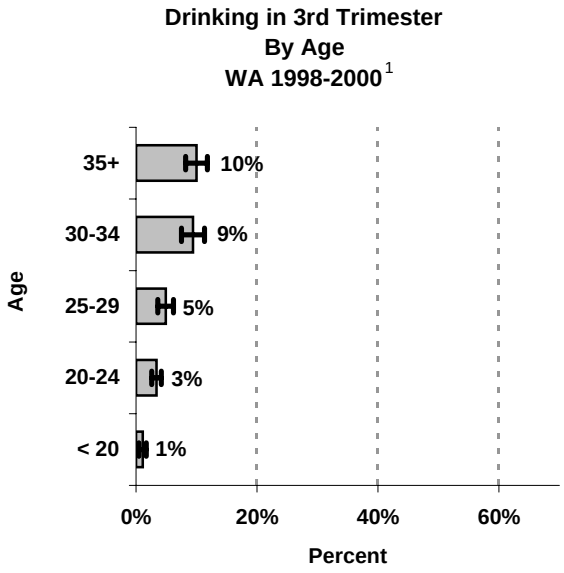
Drinking Before Pregnancy



Binge Drinking



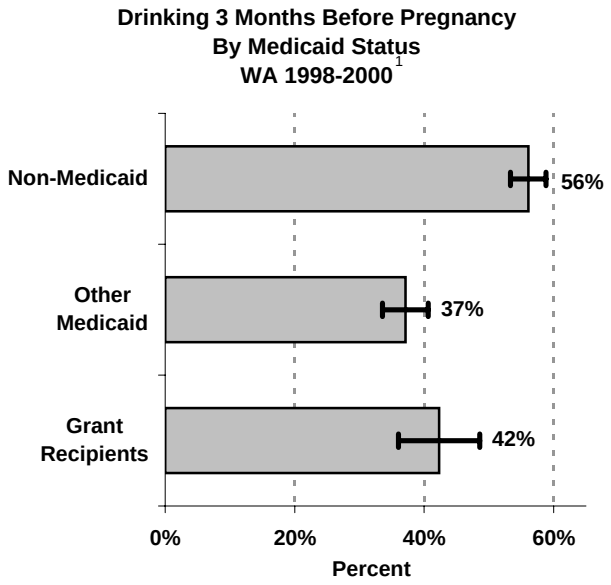
Third Trimester



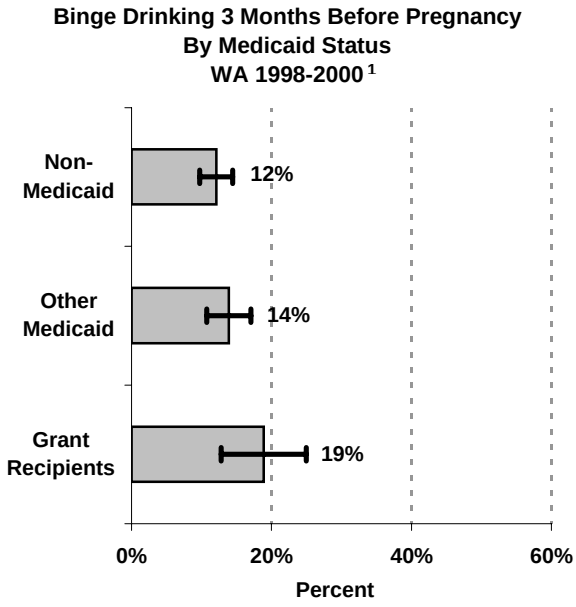
Alcohol Use During Pregnancy (cont.)

Alcohol Use in Pregnancy By Medicaid Status*[,b]

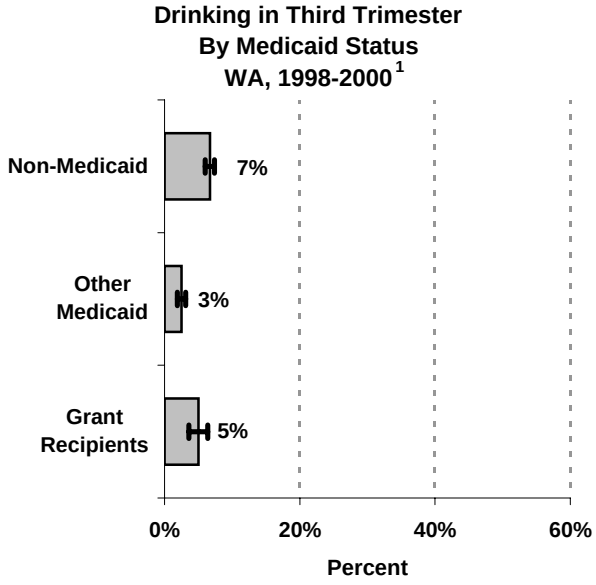
Drinking Before Pregnancy



Binge Drinking



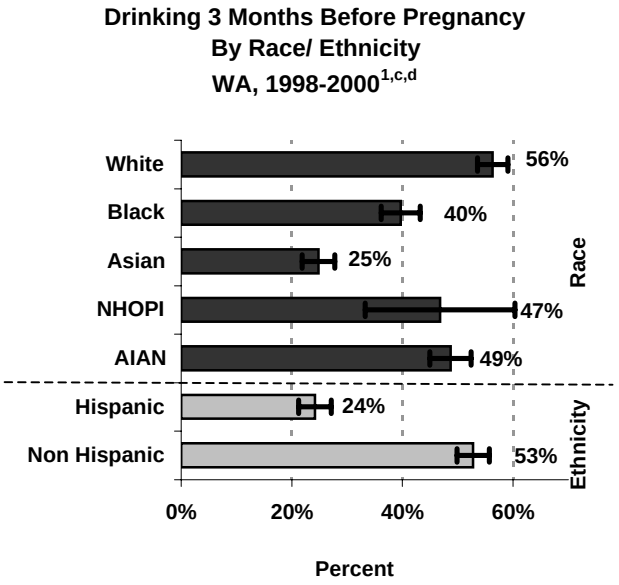
Third Trimester



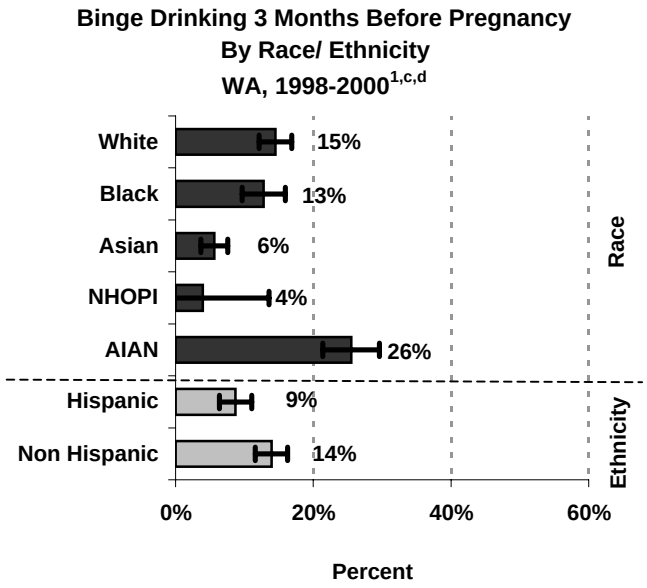
*Medicaid women had either prenatal care or delivery paid by Medicaid. Medicaid women include those who are very low income and receive cash assistance (TANF) in addition to Medicaid **[Grant Recipients]** and those who receive Medicaid with no cash assistance **[Other Medicaid]**.

Alcohol Use in Pregnancy By Race and Ethnicity

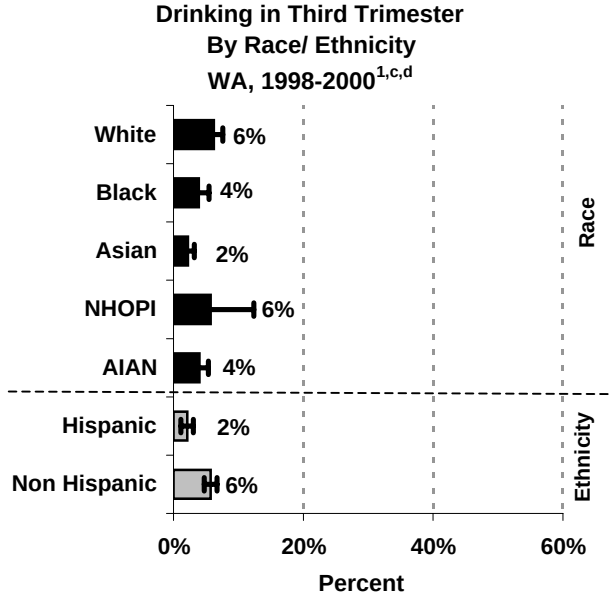
Drinking Before Pregnancy



Binge Drinking



Third Trimester



Data Sources

[1] Washington Pregnancy Risk Assessment Monitoring System (PRAMS), 1998-2000.

[2] Department of Health and Human Services (US). Healthy People 2010: Understanding and Improving Health. 2nd edition. Washington, DC: US Government Printing Office; November 2000.

Endnotes

[a] Significance is based on 95% Confidence Intervals.

[b] The source for the Medicaid designations used in PRAMS is the Washington State Department of Social and Health Services, First Steps Database.

[c] AIAN - American Indian Alaskan Native

[d] NHOPI- Native Hawaiian Other Pacific Islander

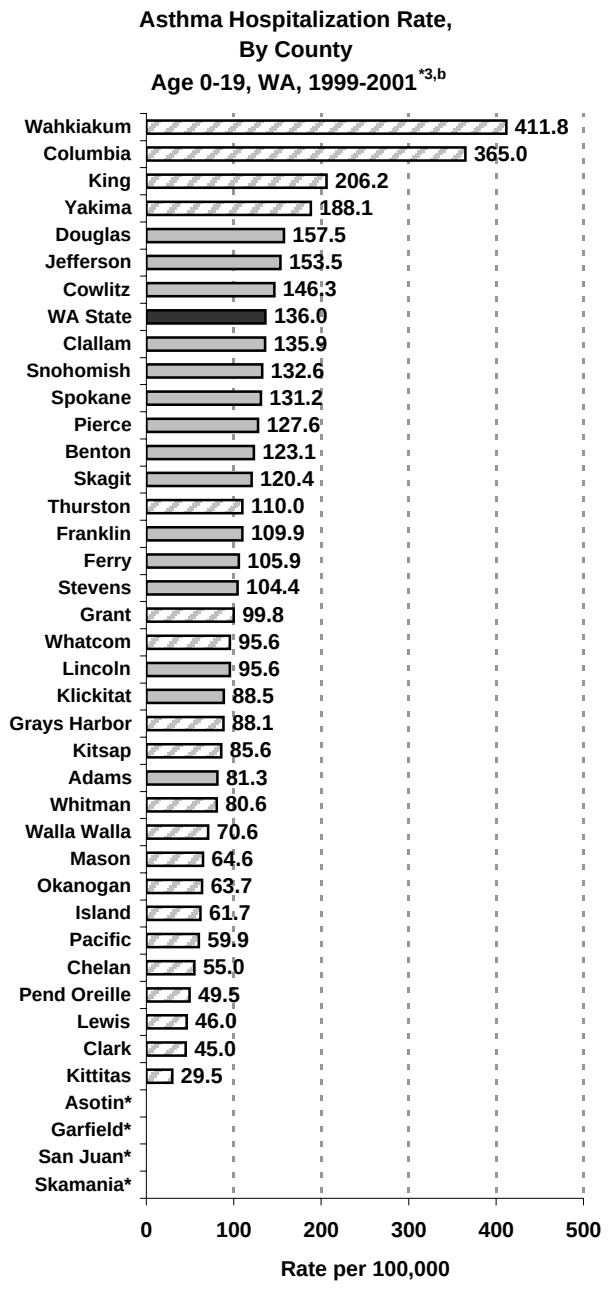
Asthma

Definition: Asthma is a condition that causes inflammation and obstruction of the respiratory tract. [a]

Key Findings

- **Based on survey data from the Behavioral Risk Factor Surveillance System (BRFSS), the prevalence of asthma in Washington children based on reporting by an adult respondent in 1999-2000 was an estimated 7% for ages 0-4, 11% for ages 5-12, and 13% for ages 13-17.[1]**
- **Approximately 19% of 10th and 12th Graders, 18% of 8th Graders, and 13% of 6th Graders responding to the 2002 school-based Healthy Youth Survey (HYS) reported they had ever been told by a health professional that they had asthma.[2]**
- **In 2001, there were 2,172 asthma-related hospitalizations for Washington children ages 0-19 and 6 asthma-related deaths, for a hospitalization rate of 130 per 100,000 population and 0.4 deaths per 100,000 population.[3,4,5,c]**
- **Asthma hospitalization rates were highest in infants and children 1-4. Washington males had higher asthma hospitalization rates than females. The most urban and the most rural parts of the state had the highest rates of asthma hospitalization. [3]**
- **The Healthy People 2010 objectives for asthma are to reduce deaths from asthma for children ages <5 and 5-14 to no more than 0.1 per 100,000, and for ages 15-34 to no more than 0.2 per 100,000 and to reduce asthma hospitalizations for ages <5 to no more than 250 per 100,000 and for ages 5-64 to no more than 77 per 100,000. [6]**

County

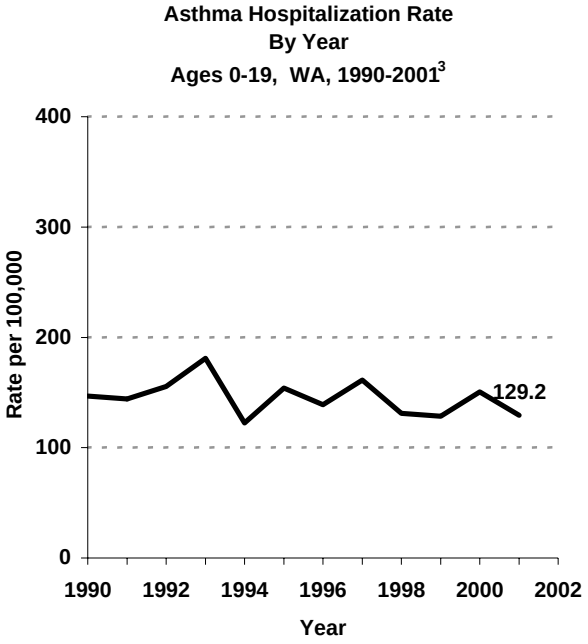


*County rates not calculated if less than 5 events.

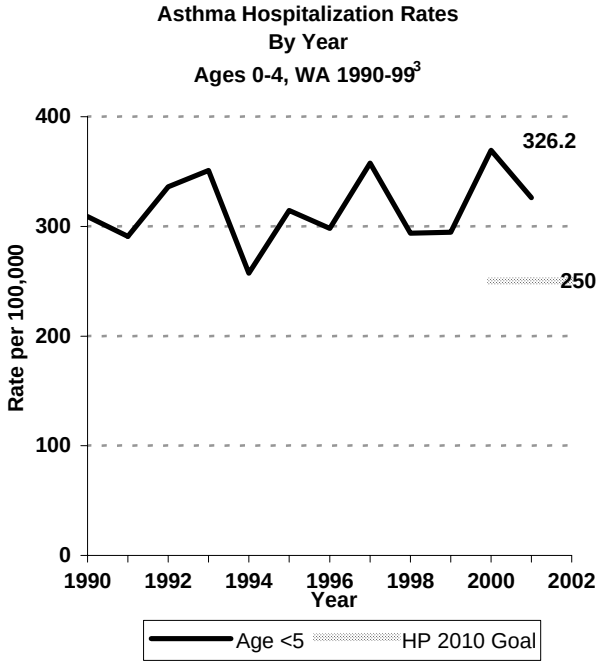
Significantly different from state rate

Asthma (cont.)

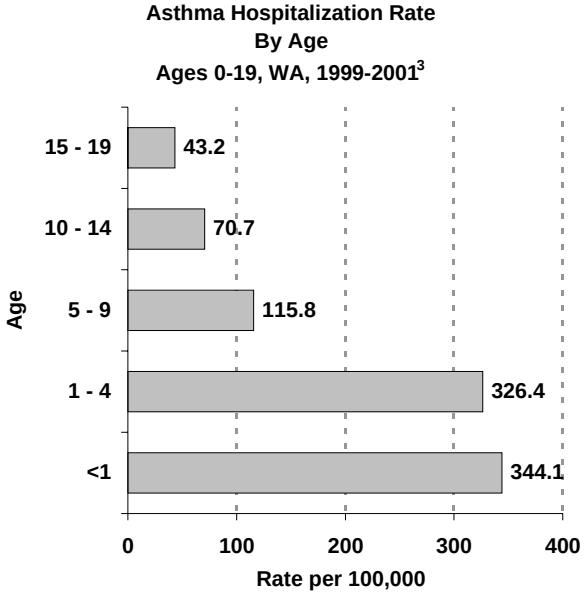
Time Trend



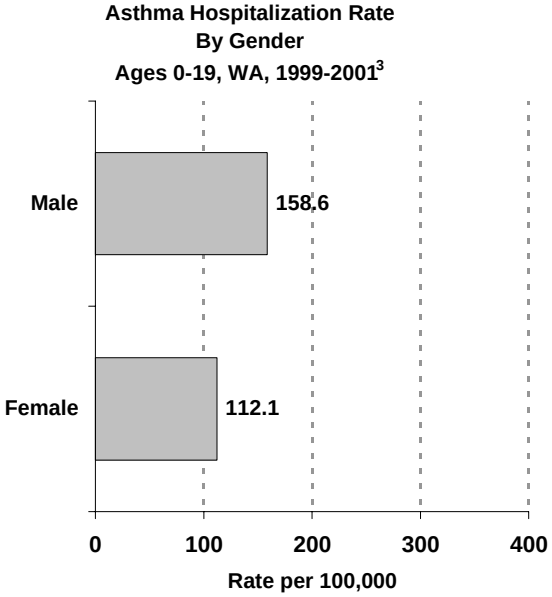
Hospitalization <5 years of age



Age

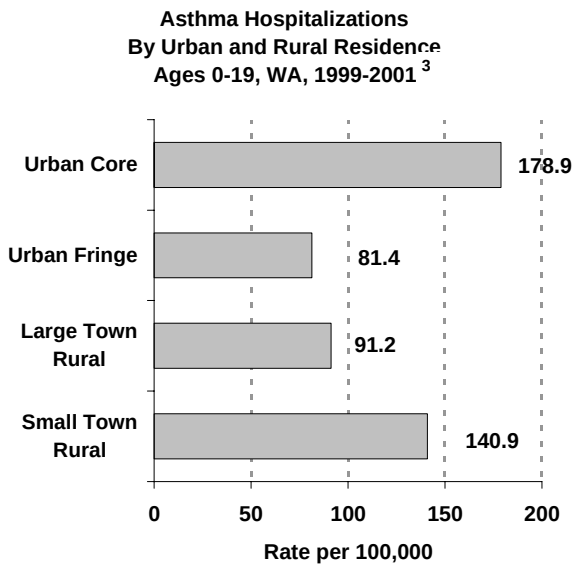


Gender

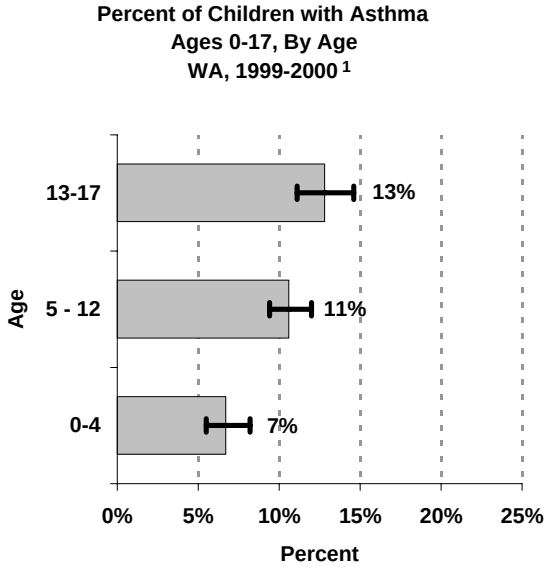


Asthma (cont.)

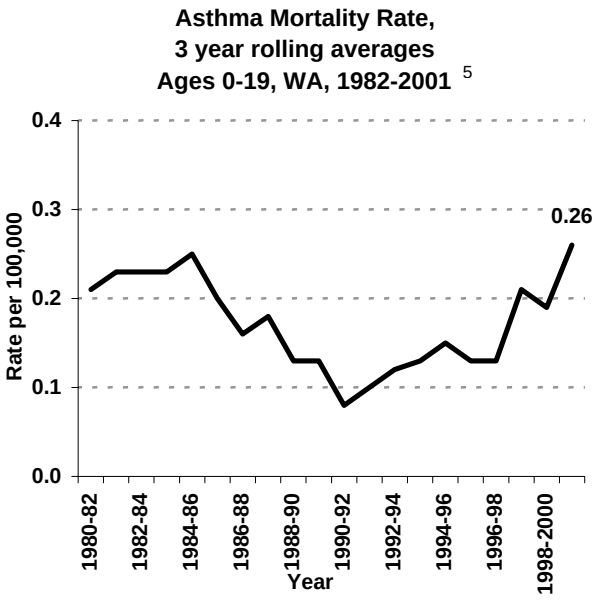
Rural and Urban Residence



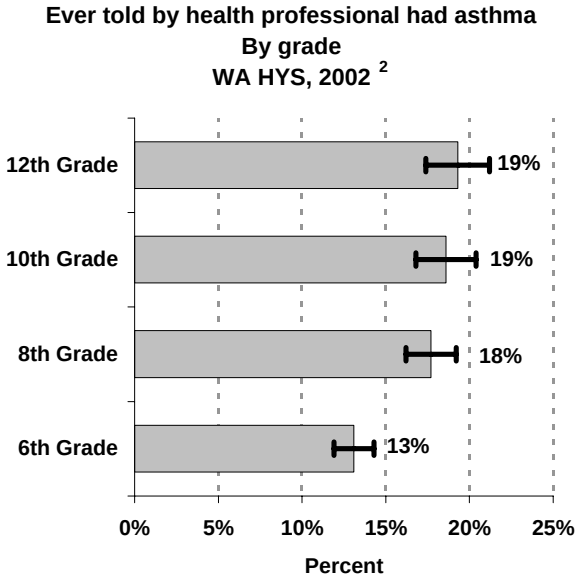
Behavioral Risk Factor Surveillance System (BRFSS) data



Mortality: 3 year rolling averages



Healthy Youth Survey 2002



Asthma (cont.)

Data Sources

[1] Behavioral Risk Factor Surveillance System (BRFSS), Washington State Department of Health, 1999-2000.

[2] Washington State Office of Superintendent of Public Instruction, Department of Health, Department of Social and Health Services, and Department of Community, Trade, and Economic Development and RMC Research Corporation. Washington State Healthy Youth Survey 2002: Analytic Report. In preparation.

[3] Comprehensive Hospital Abstract Reporting System (CHARS), Washington State Department of Health, 1990-2001.

[4] Analysis Software: Public Health - Seattle & King County, Epidemiology, Planning & Evaluation, Software for Public Health Assessment (VistaPHw), 1991-

[5] Death Certificate Data: Washington State Department of Health, Center for Health Statistics, 1999-2001.

[6] Healthy People 2010: Understanding and Improving Health, US Department of Health and Human Services, Washington DC US Government Printing Office, 2000.

Endnotes:

[a] Asthma deaths include ICD-10 codes J45-J46, and deaths before 1999 include ICD-9 CM codes 493.Comparability ratio 0.8938. Asthma hospitalizations include ICD-9 CM codes 493. The hospitalization data source is the Washington State Comprehensive Hospital Abstract Reporting System (CHARS), and duplicate cases are included.

[b] Significance is based on 95% confidence intervals.

[c] Hospitalization data represent only the most severe cases and underrepresent the true burden of asthma in the state .

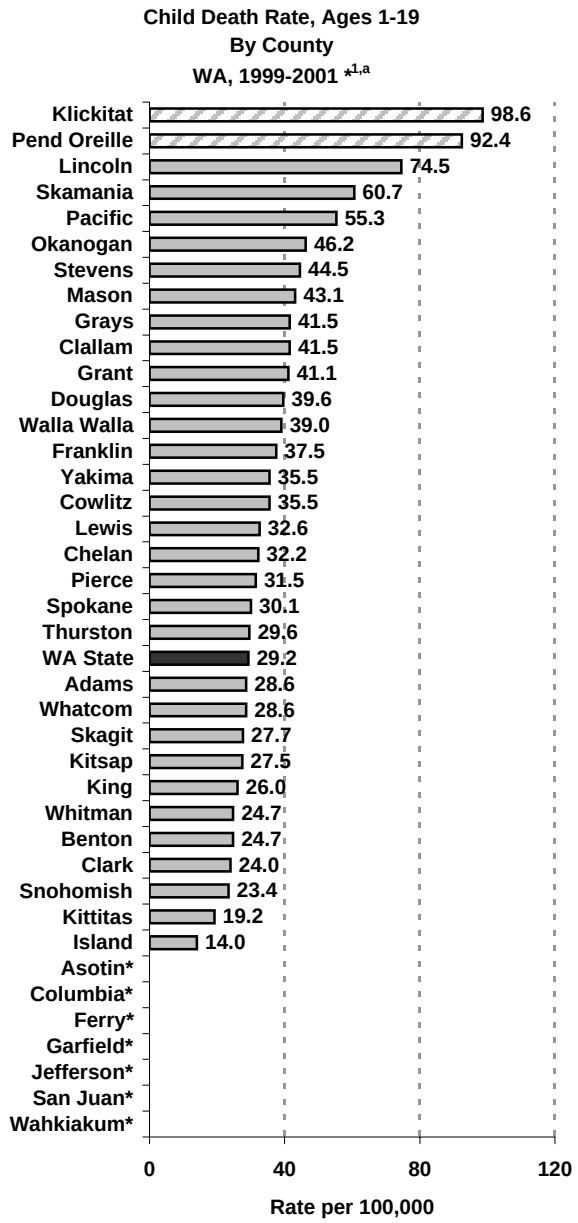
Child Mortality

Definition: Child mortality is the death of a child ages 1 through 19. This age range is chosen because it reflects the national performance measures from the Maternal and Child Health Bureau.

Key Findings

- **There were 454 deaths to children ages 1-19 in Washington state in 2001. Unintentional injuries accounted for 45% of the deaths, followed by suicide and homicide (16%), malignant neoplasms (12%) and congenital malformations (6%).[1,2]**
- **Child death rates in Washington have decreased significantly over time: from 56.8 per 100,000 children ages 1-19 in 1980 to 28.1 per 100,000 in 2001. This mirrors a national trend.[1,3,a]**
- **Death rates and causes differ substantially by the child's age. The highest death rates for Washington state children are in children ages 15-19 and children ages 1-4. Unintentional injuries are the leading cause of death for Washington children ages 1-19, followed by malignant neoplasms for children ages 1-14 and suicides for children ages 15-19.[4]**
- **Child death rates are higher for male children and children who are Black or American Indian/ Alaska Native. Small town/rural areas have significantly higher child mortality rates than more urban areas in the state.[1,a]**
- **The Healthy People 2010 goals for child mortality are no more than 18.6 deaths per 100,000 for ages 1-4, <=12.3 for ages 5-9, <=16.8 for children ages 10-14, and <=39.8 for ages 15-19. [5]**

County

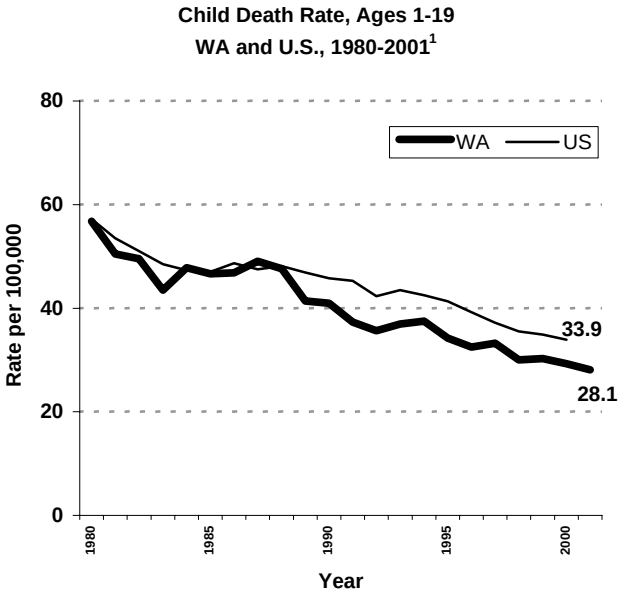


** County rate not calculated if fewer than 5 events*

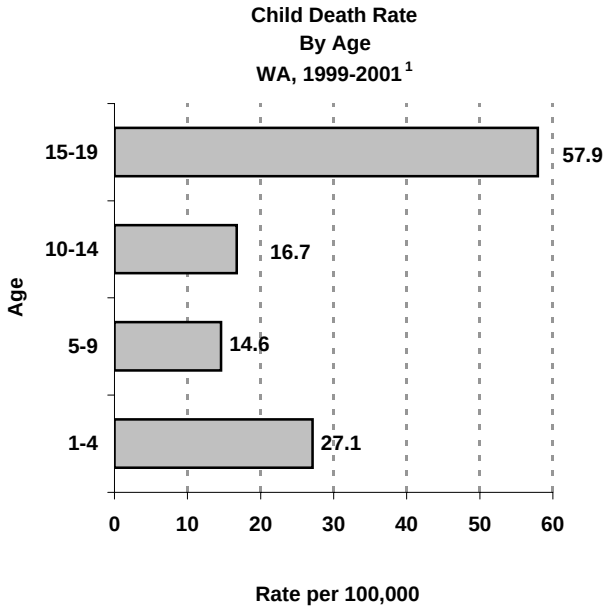
Significantly different from state

Child Mortality (cont.)

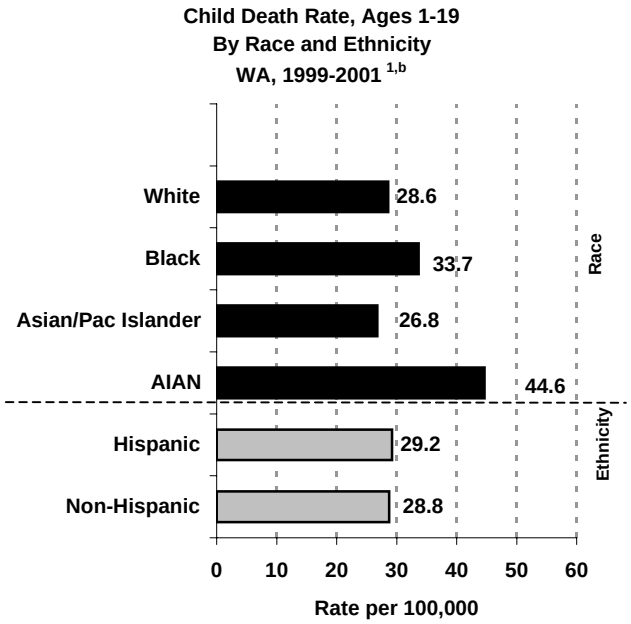
Time Trend



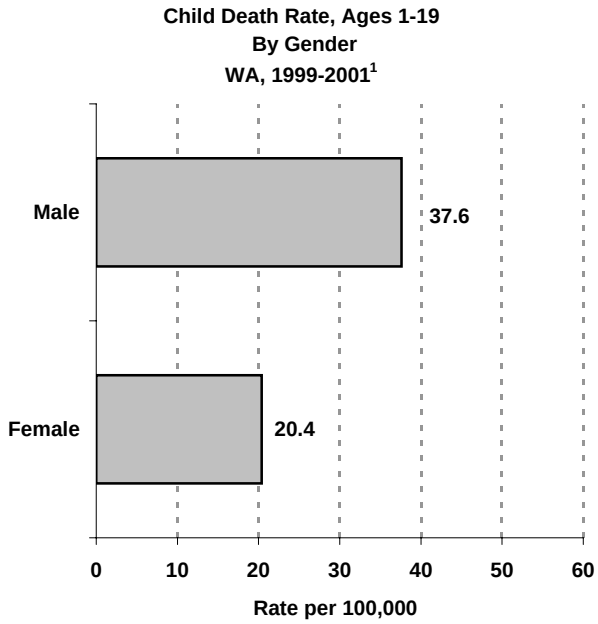
Age



Race and Ethnicity



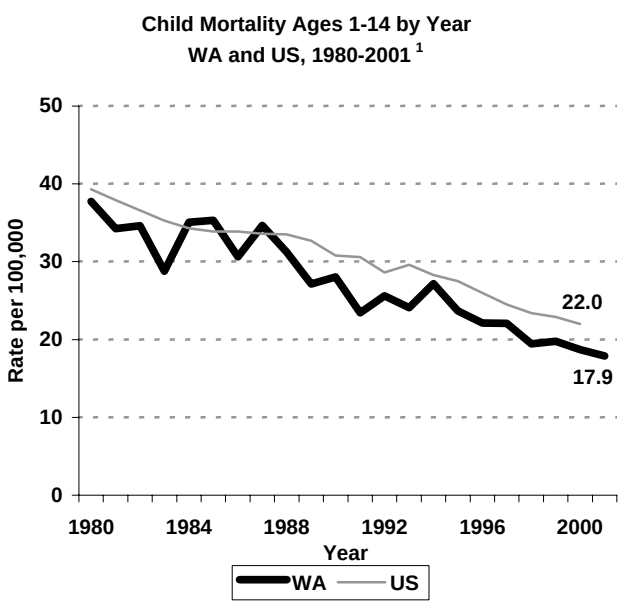
Gender

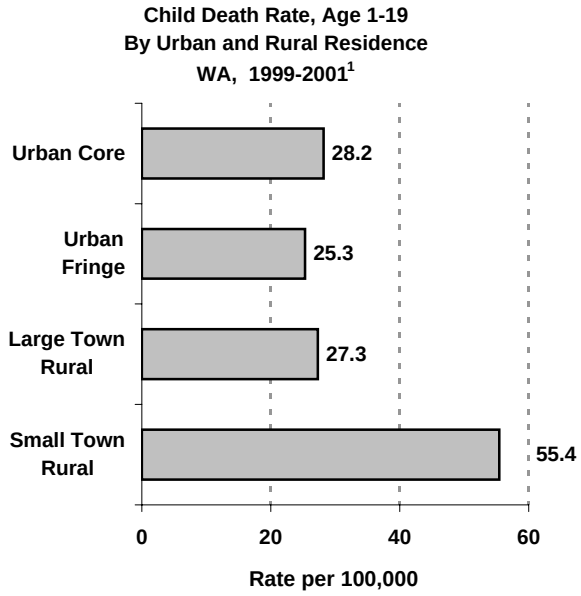


Child Mortality (cont.)

Block Grant Outcome Measure: Child death rate per 100,000 children aged 1-14.

Rural and Urban Residence





Leading Causes of Child Mortality, 1999-2001 [4]

by Age Group

Rank	1 - 4	5 - 9	10 - 14	15 - 19
1st	Accidents and external causes	Accidents and external causes	Accidents and external causes	Accidents and external causes
2nd	Malignant Neoplasms	Malignant Neoplasms	Malignant Neoplasms	Malignant Neoplasms
3rd	Congenital malformations/ chromosomal anomalies	Congenital malformations/ chromosomal anomalies	Suicides	Suicides

Data Sources

[1] Washington State death certificate data: Vital Statistics 2001, Washington State Department of Health, Center for Health Statistics, December 2002.

[2] Analysis Software: Public Health - Seattle & King County, Epidemiology, Planning & Evaluation, Software for Public Health Assessment (VistaPHw), 1991-.

[3] CDC Wonder, National Center for Health Statistics.

[4] Injury Prevention and Safety Program, Washington State Department of Health: http://www.doh.wa.gov/cfh/Injury/Tables_update.htm .

[5] Department of Health and Human Services (US). Healthy People 2010: Understanding and Improving Health. 2nd edition. Washington, DC: US Government Printing Office; November 2000.

Endnotes

[a] Significance was determined based on 95% Confidence Intervals.

[b] AIAN - American Indian and Alaskan Native

Child Weight and Physical Activity

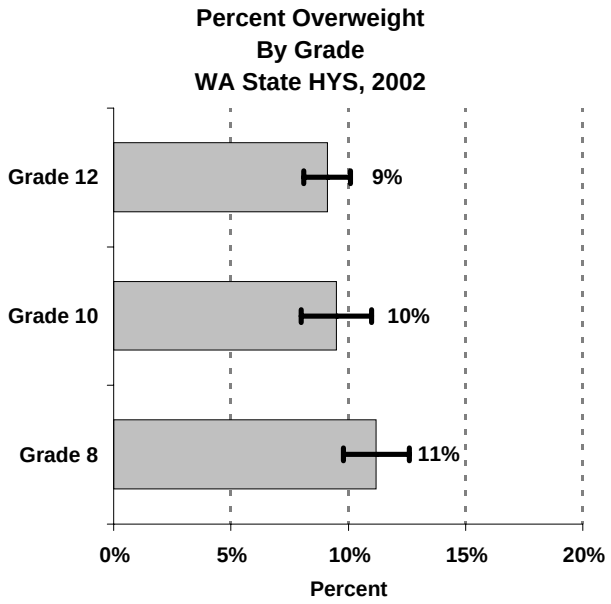
Definition: Children are considered overweight if they are in the top 5% for body mass index by age and gender based on growth charts developed by the Centers for Disease Control and Prevention (2000). Students are considered at risk for being overweight if they are in the top 15% but not in the top 5%.

Key Findings

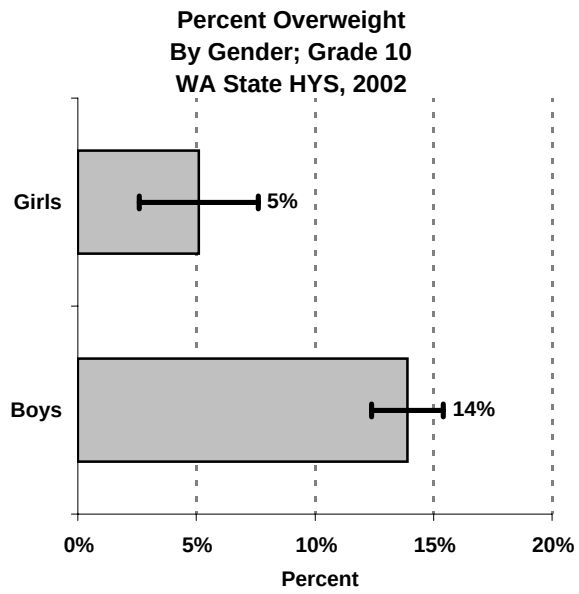
- **In 2002, about 10% of Washington 8th, 10th and 12th graders were overweight based on self-reported height and weight. Nationally, the percentage of children and adolescents who are defined as overweight has more than doubled since the early 1970s. About 15% of United States children and adolescents are now overweight.[1,3]**
- **In Washington, about a third of students in grades 8, 10 and 12 reported engaging in moderate physical activity (at least 30 minutes 5 or more days a week). The Healthy People 2010 target is for 35% of adolescents to engage in moderate physical activity.[1,2]**
- **Older students are less likely than younger students to engage in vigorous cardiovascular exercise. In Washington, approximately 75% of students in Grades 8 and 10, and about two-thirds of students in Grade 12 engaged in vigorous physical activity (at least 20 minutes 3 or more days a week). The Healthy People 2010 target is for 85% of adolescents to engage in vigorous physical activity.[1,2]**
- **In Washington, older students are more likely to report that they did not attend a physical education class in an average week: About 30% of 8th graders did not attend a physical education class in an average week compared to about 60% of 12th graders.[2]**
- **Generally, boys are more likely than girls to engage in daily vigorous physical activity: For instance, among 12th graders, about 70% of boys meet the recommendations for physical activity, as compared to about 57% of girls.[2]**
- **More than one in four Washington State 8th graders report drinking 2 or more sodas the previous day. Students who regularly eat dinner with their family are more likely to eat fruits and vegetables 5 times or more a day, and are less likely to have had two or more sodas on the previous day. (Data not shown)[2]**
- **Students who watch television 3 or more hours a day during school days were about twice as likely to be overweight than students who watch television 2 of less hours a day. The Healthy People 2010 objective is to increase the proportion of adolescents who view television 2 or fewer hours on a school day to 75%.[1,2]**

Child Weight and Physical Activity (cont.)

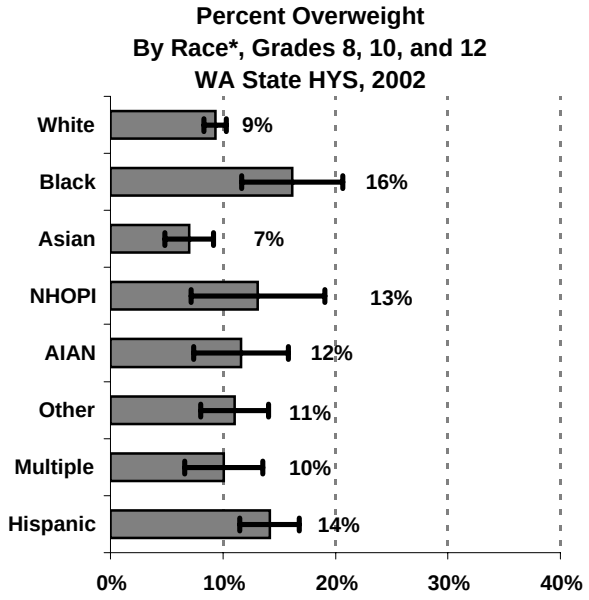
Grade



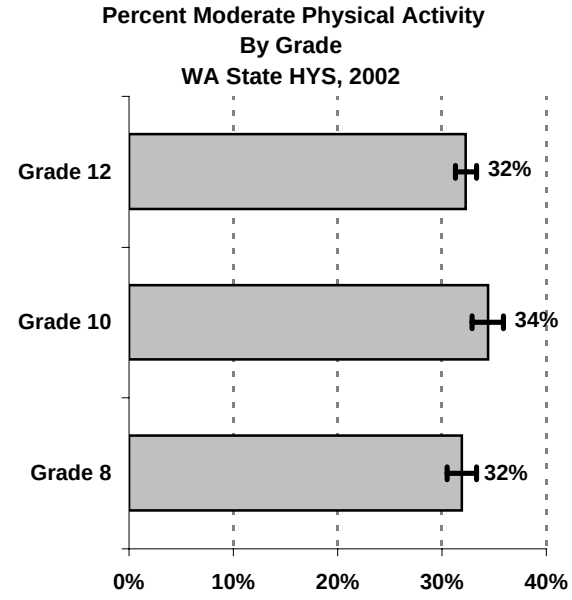
Gender



Race and Ethnicity



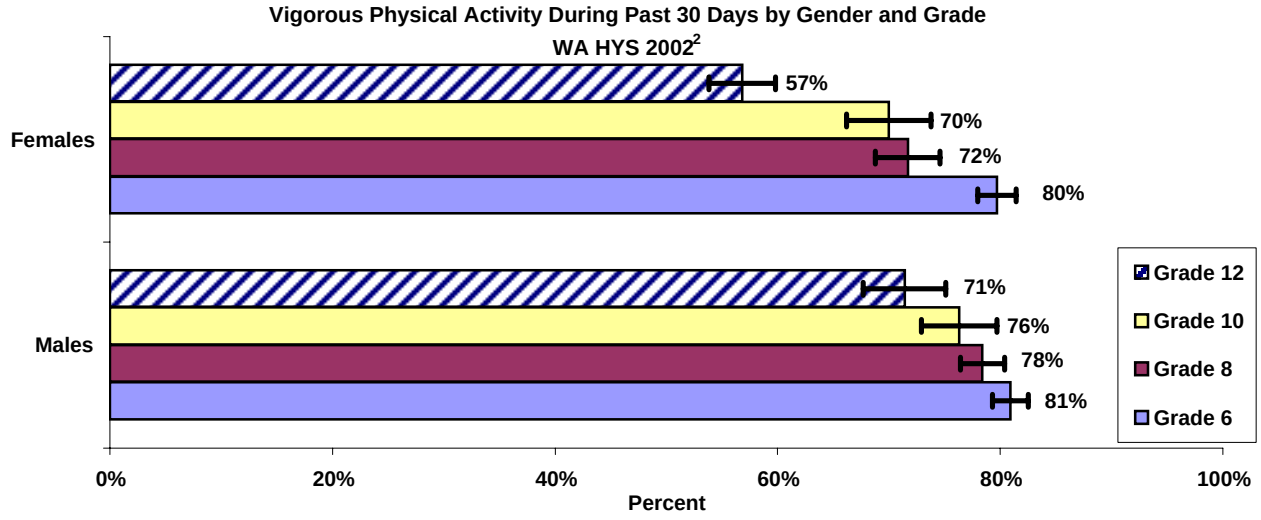
Moderate Physical Activity



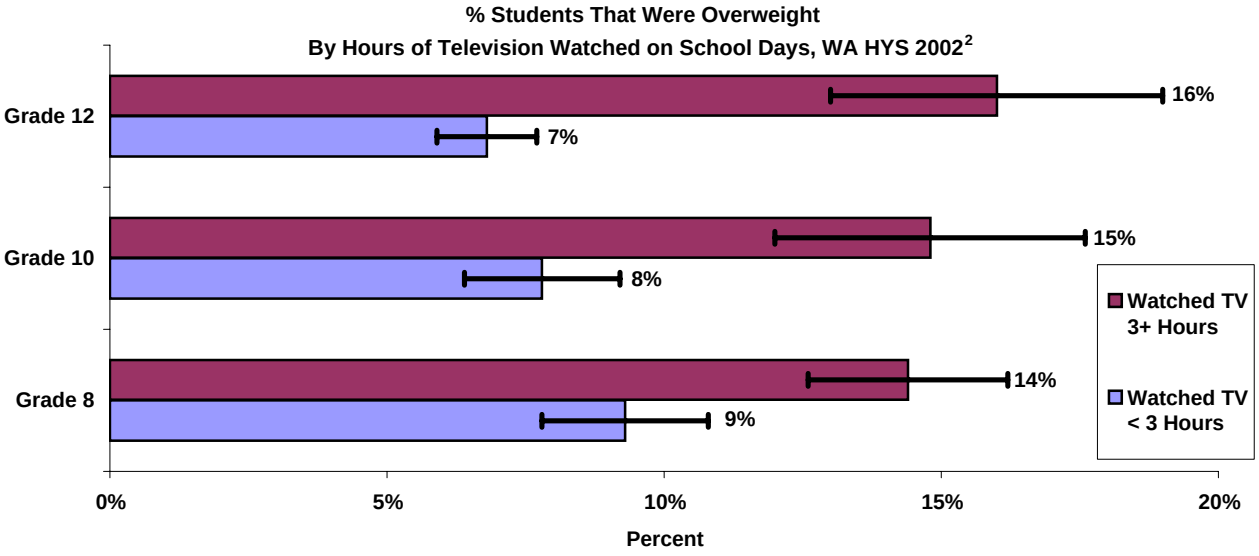
**In the Healthy Youth Survey, Hispanic ethnicity is asked in the same question as race. Students are asked to choose one or more races, including Hispanic ethnicity, as appropriate.*

Child Weight and Physical Activity (cont.)

Physical Activity



Television Watching



Data Sources

[1] Department of Health and Human Services (US). Healthy People 2010: Understanding and Improving Health. 2nd edition. Washington, DC: US Government Printing Office; November 2000.

[2] Washington State Office of Superintendent of Public Instruction, Department of Health, Department of Social and Health Services, and Department of Community, Trade, and Economic Development and RMC Research Corporation. Washington State Healthy Youth Survey 2002: Analytic Report. In preparation.

[3] Health United States 2002, National Center for Health Statistics, Centers for Disease Control and Prevention.

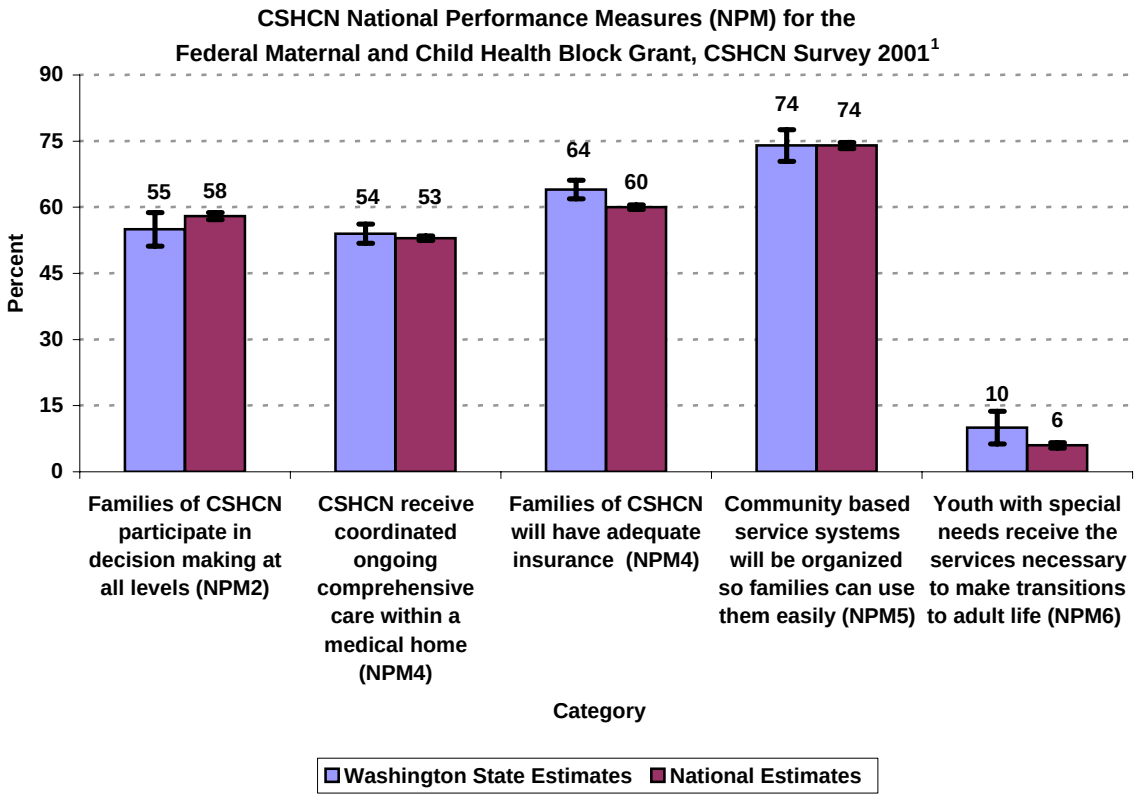
Children with Special Health Care Needs

Definition: Children with special health care needs are those who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who require health and related services of a type or amount beyond that required by children generally.[a]

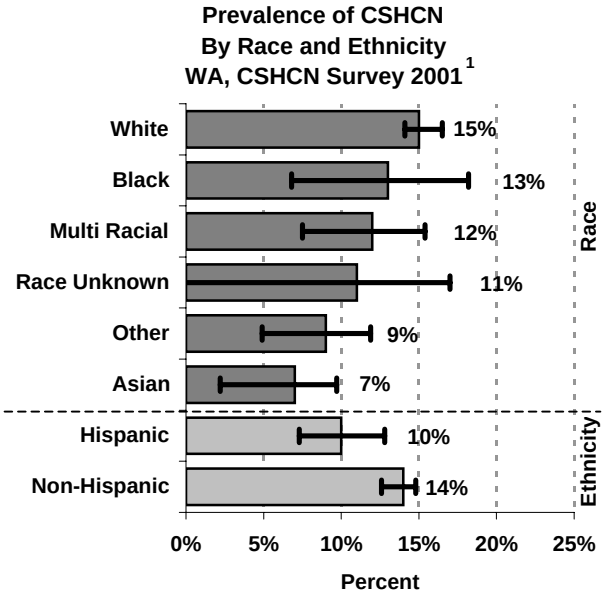
Key Findings

- **Results from the 2001 National Children with Special Health Care Needs (CSHCN) Survey indicate that approximately 14% or 211,000 children ages 0-17 in Washington have special needs compared to the national average of 13%.[1]**
- **In Washington state, males (16%) are more likely to have a special health care need than females (12%), and non-Hispanics (14%) are more likely to have a special need than Hispanics (10%). A significantly higher prevalence of special health care needs is reported among Washington state children who were school age compared to children under age 5. This higher prevalence may be a result of more special needs getting identified when children enter school.[1]**
- **An estimated 54% of Washington's children with special needs received care within a medical home, compared to the national estimate of 53%. A medical home is an approach to providing health care in a high-quality and cost-effective manner through a partnership between families and providers. Children receive the care they need from a pediatrician and other health care professionals and are able to access all the medical and nonmedical services needed to help them achieve their maximum potential.[1,b]**
- **In 2002, approximately 12,000 children were enrolled in local CSHCN Programs in Washington State. Local CSHCN Programs provide a variety of services, including care coordination, assessment, and information referral. Local programs only interact with a small percentage of the estimated population because of capacity issues in the service delivery system.[3]**
- **In Washington state, children with special needs were significantly more likely to be adequately insured for the services they needed, compared to children with special needs nationally. Services most reported as being needed by children with special needs in Washington state are prescription medications, dental care and routine care. Fifty two percent of these children needed to see a specialist and about 28% needed mental health care.[1]**
- **Based on the 2002 Consumer Assessment of Health Plans (CAHPS) of Washington Medicaid enrollees, there is a uniform distribution of children with a chronic condition and children without a chronic condition across the CSHCN regions in Washington State.[2]**

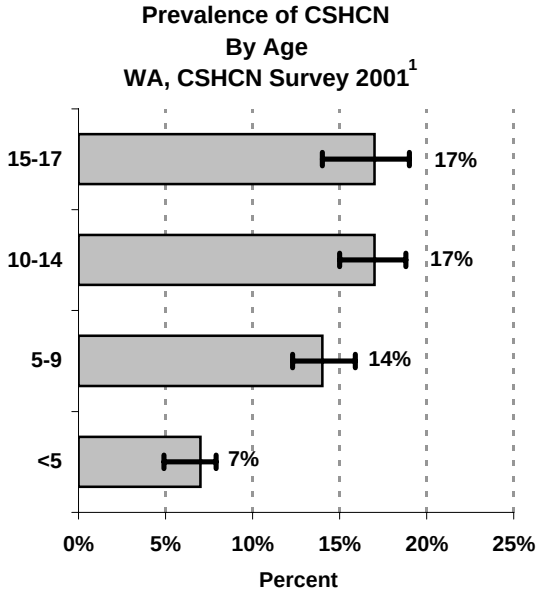
Children with Special Health Care Needs (cont.)



Race and Ethnicity



Age



Children with Special Health Care Needs (cont.)

Table 1. Differences in health services between CSHCN and non-CSHCN, 2002 Washington State Medicaid Client Satisfaction Survey[2]

(Note: All differences reported below are statistically significant)

	CSHCN	Not CSHCN
	Estimated %	Estimated %
Getting Needed Care		
Big problem getting care you needed*	5%	2%
Big problem getting child's medicine*	8%	3%
Big problem getting OT, PT, Speech*	22%	13%
Big problem getting needed referral to specialist*	14%	9%
Got appointment for routine care**	13%	15%
Rating Providers/ Plan		
Specialty doctor rated 0-5 on scale of 10 (best)***	11%	8%
Personal Doctor or nurse rated 0-5 on scale of 10 (best)***	8%	6%
All experiences with child's health plan rated 0-5 on scale of 10 (best)	13%	8%
Doctor's communication		
Providers sometimes or never respect what you say**	8%	6%
Child not able to talk with provider about his/ her health care	24%	39%
Care Coordination		
No one from plan helps coordinate care from multiple providers	36%	47%

*CSHCN were statistically significantly more likely than non-CSHCN to report this issue as a big problem compared to a small or no problem.

**Sometimes or never versus usually or always

*** Rated 05 versus 6-10 with 0 being worst and 10 being best

Data Sources

[1] 2001 National CSHCN Survey, Department of Health and Human Services, CDC, National Center for Health Statistics, Hyattsville, Maryland, April 28,2003.

[2] 2002 Consumer Assessment of Health Plans Survey, Child Survey, Analyses prepared by Ginny Sharp and Jacquie Stock, Center for Children with Special Needs, Children's Hospital and Regional Medical Center, under contract with the State Department of Health CSHCN Program.

[3] 2002 Annual Count, Child Health Intake Form (CHIF), Washington State Department of Health

Endnotes

[a] Maternal and Child Health Bureau Title V Children with Special Health Care Needs definition

[b] American Academy of Pediatrics, AAP definition, 2004.

Food Insecurity and Hunger

Definition: Food insecurity is the limited or uncertain availability of nutritionally adequate and safe foods, or limited or uncertain ability to acquire acceptable foods in socially acceptable way. Hunger is the uneasy or painful sensation caused by a lack of food, and the recurrent and involuntary lack of access to food.

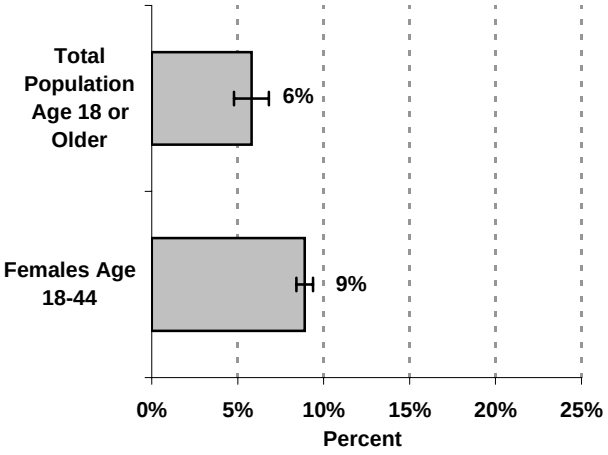
Key Findings

- **According to data from the Current Population Survey, over the period of 1998-2000, an estimated 13% of Washington's households were food insecure, and an estimated 5% of households were food insecure with hunger, compared to about 11% of US households that were food insecure, and 3% that were food insecure with hunger. Washington State ranks second in the nation for food insecurity with hunger.[1]**
- **In Washington, having a low income, being a non-white race, and having children is strongly associated with food insecurity and hunger.[1]**
- **Based on 1995-99 survey data from the Behavioral Risk Factor Surveillance System (BRFSS), Washington State adults over age 18 reported that in the 30 days before the survey: about 5% were concerned about having enough food, 3% skipped meals because there was not enough money to buy food, and 1% went without food for an entire day. Seven percent of women ages 18-44 reported they were concerned about having enough food, 5% skipped meals because there was not enough money to buy food, and 2% went without food for an entire day. [2]**
- **Data were not available on the food security of young children. However, some data on adolescents are available. In the 2002 Washington Healthy Youth Survey, about one in seven students reported that their family had reduced or skipped meals in the last 12 months because there was not enough money to buy food.[3]**
- **Health effects of hunger and food insecurity in children are associated with having more psychosocial problems, frequent colds, ear infections, anemia, asthma and frequent headaches.[4,5]**
- **The Healthy People 2010 objective is to increase the prevalence of food security among US households to at least 94 percent of all households.[6]**

Food Insecurity (cont.)

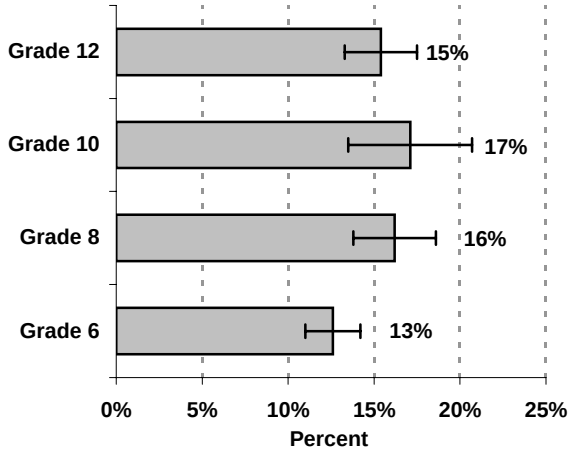
Gender and Age

Percent Reporting Food Insecurity, Skipping Meals, or Not Eating for an Entire Day By Population WA State BRFSS, 1995-1999 [2]



Grade

Family Reduced or Skipped Meals in Last Year Because There Wasn't Enough Money to Buy Food By Grade WA, Healthy Youth Survey 2002 [3]



Data Sources

[1] Sullivan, A., Choi, E. Hunger and Food Insecurity in the Fifty States: 1998--2000. Food Security Institute, Center on Hunger and Poverty, Heller School for Social Policy and Management, Brandeis University. August 2002.

[2] Behavioral Risk Factor Surveillance System (BRFSS), Washington State Department of Health, 1995-1999

[3] Washington State Office of Superintendent of Public Instruction, Department of Health, Department of Social and Health Services, and Department of Community, Trade, and Economic Development and RMC Research Corporation. Washington State Healthy Youth Survey 2002: Analytic Report. In preparation.

[4] Prevalence of Food Insecurity and Hunger, by State, 1996-1998. Food and Rural Economics Division, Economic Research Service, US Department of Agriculture. Food Assistance and Nutrition Research Report No.2. Sept 1999.

[5] Olson, CM. Nutrition and health outcomes associated with food insecurity and hunger. J Nutr 1999; 129:521-24S.

[6] Department of Health and Human Services (US). Healthy People 2010: Understanding and Improving Health. 2nd edition. Washington, DC: US Government Printing Office; November 2000.

Immunizations/ Vaccine Preventable Diseases

Definition: The standard measure of appropriate immunization for two-year olds are a series of vaccinations that includes 4 doses diphtheria, tetanus, pertussis (DTP or DTaP), 3 doses polio, 1 dose measles, mumps and rubella (MMR), 3 doses haemophilus influenzae type b (Hib) and 3 doses Hepatitis B (4:3:1:3:3).

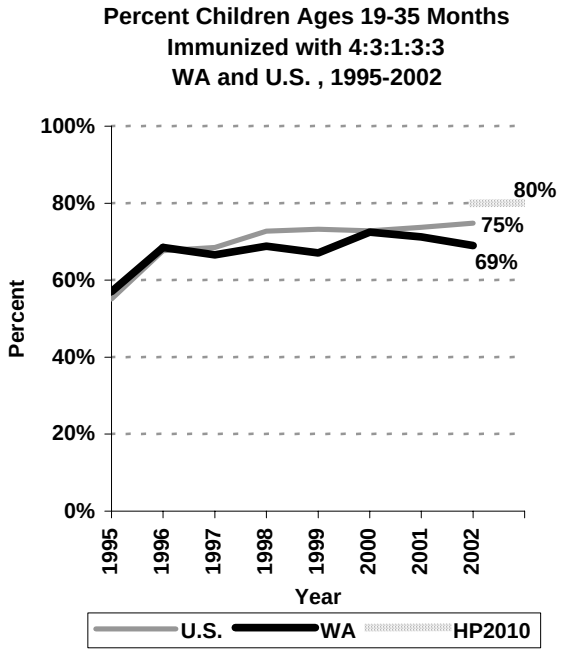
Key Findings

- **In 2002, estimated vaccination coverage from the National Immunization Survey (NIS) for all recommended immunizations (4:3:1:3:3) among children 19-35 months of age in Washington State was 69.2% (±5.0), comparable to the 2001 national rate of 74.8% (±1.0).** [1]
- **In 2002, Washington partially met its goal to ensure that at least 95 percent of children entering kindergarten or first grade (school entry-level) are adequately immunized. Immunization rates were DTP/DTaP: 90.5%, Polio: 92.5%, Measles: 92.3%, Mumps: 95.0%, Rubella: 95.0%, and Hep B: 95.1%.** [2]
- **Underimmunization can occur when needed vaccines are not administered during acute or chronic care medical visits and when multiple vaccines are not given during the same visit. Transportation problems, lack of immunization schedule at home, multiple family moves, multiple providers, and objections to some immunizations may also serve as barriers to adequate immunization. The 4th DPT, recommended to be administered between 15 and 23 months, is the most frequently missed immunization.**
- **Washington is one of only 17 states that permit immunization exemptions for school admittance due to personal or philosophical reasons. For school year 2002-2003, 32,529 children were exempt, representing 3.8% of enrolled school-age children statewide. Over 90% of those exemptions were for personal or philosophical reasons. Other exemptions are for medical and religious reasons.** [2]
- **The last diphtheria case seen in Washington was in 1979. There have been no recent wild type (non-vaccine related) polio cases in Washington and the last vaccine-related case was in 1993. In Washington State, there have been two cases of tetanus since 1997. Pertussis rates in Washington are high and there have been several years since 1995 when the rates exceeded 7 per 100,000. In 2002, Washington's pertussis incidence rates (9.5/100,000) were the 7th highest in the US and the number of cases showed a 3 fold increase from the number reported in 2001.** [3]

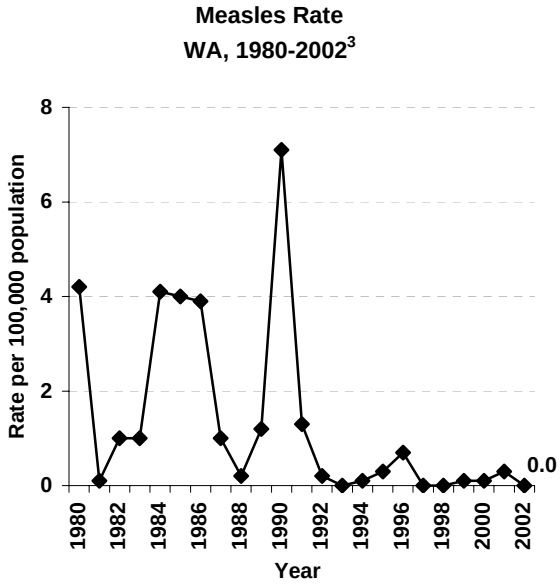
Immunizations/ Vaccine Preventable Diseases (cont.)

- **In 2002 the NIS estimated the coverage rate for varicella vaccination of children 19-35 months of age in Washington State to be 65.1% (+/- 5.1%). The coverage rates for this vaccine for the State has risen consistently since 1996 when it was 6.4% (+/- 2.2%) but has continued to remain lower than the rate for the United States as a whole which in 2002 was 80.6% (+/- 0.9%).[1]**
- **Several local Health Jurisdictions (LHJs) have conducted, or are in the process of conducting, county or other small area preschool immunization coverage surveys. These counties are Thurston, Snohomish, Grant, Grays Harbor, Spokane, Clark, King, Lincoln, Yakima, Whatcom, Benton, Franklin and Kittitas.**

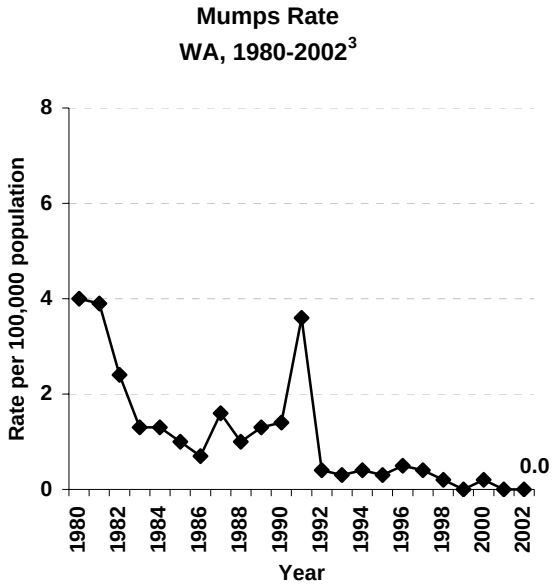
Immunization Rates



Measles Disease

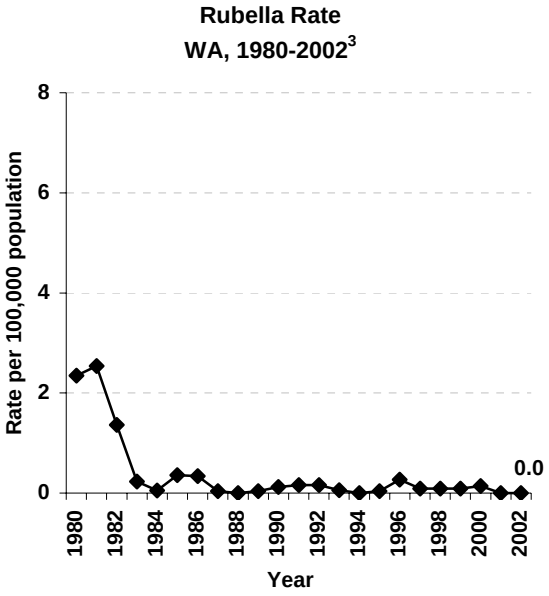


Mumps Disease

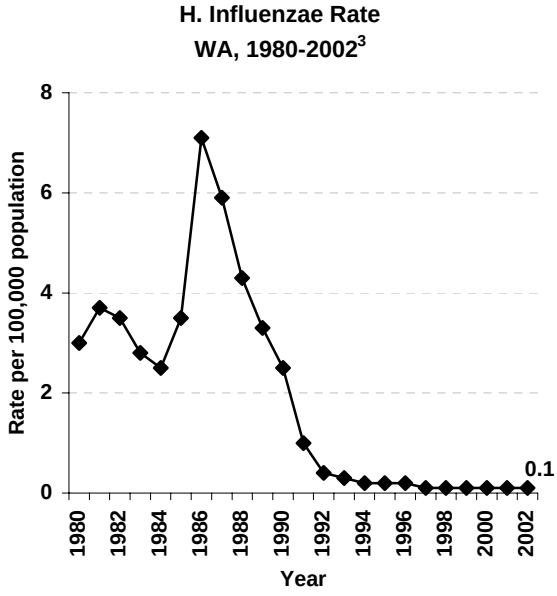


Immunizations/ Vaccine Preventable Diseases (cont.)

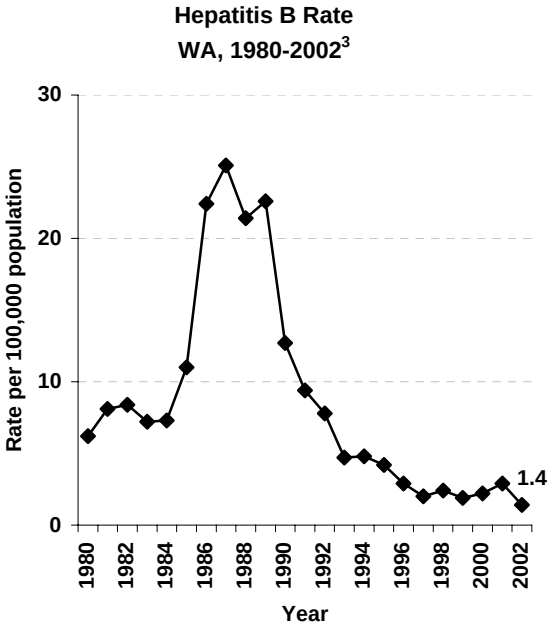
Rubella Disease



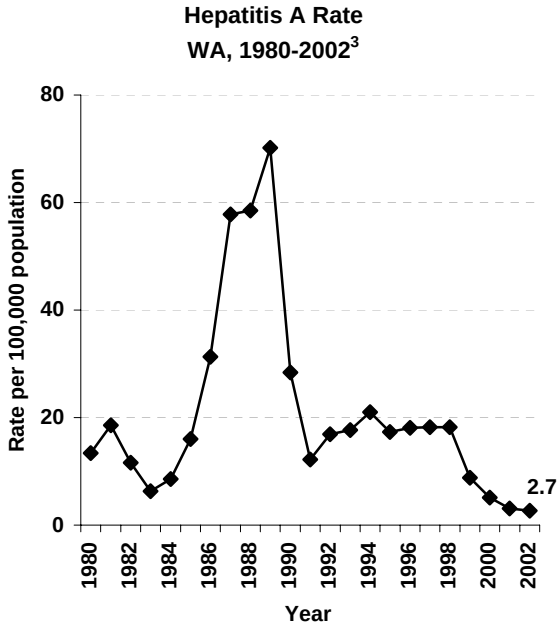
Haemophilus Influenzae, Invasive Disease



Acute Hepatitis B Disease

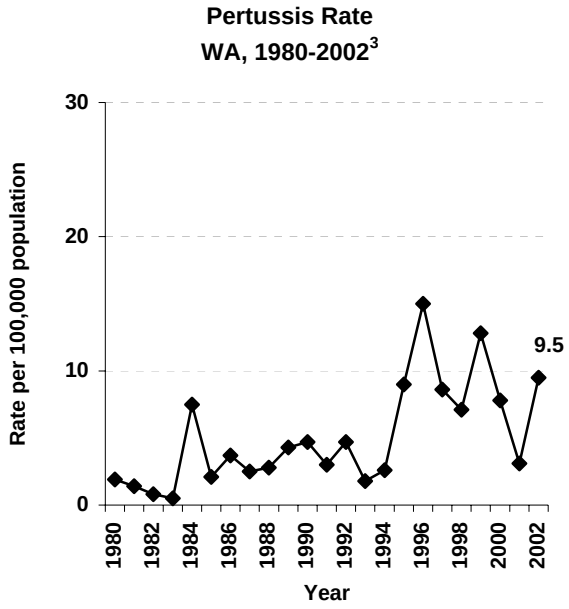


Acute Hepatitis A Disease



Immunizations/ Vaccine Preventable Diseases (cont.)

Pertussis Disease



Data Sources

[1] National Immunization Survey, Centers for Disease Control and Prevention.

[2] IMMENU School Data Software, Washington State Department of Health Immunization Program.

[3] Washington State Annual Communicable Disease Reports.

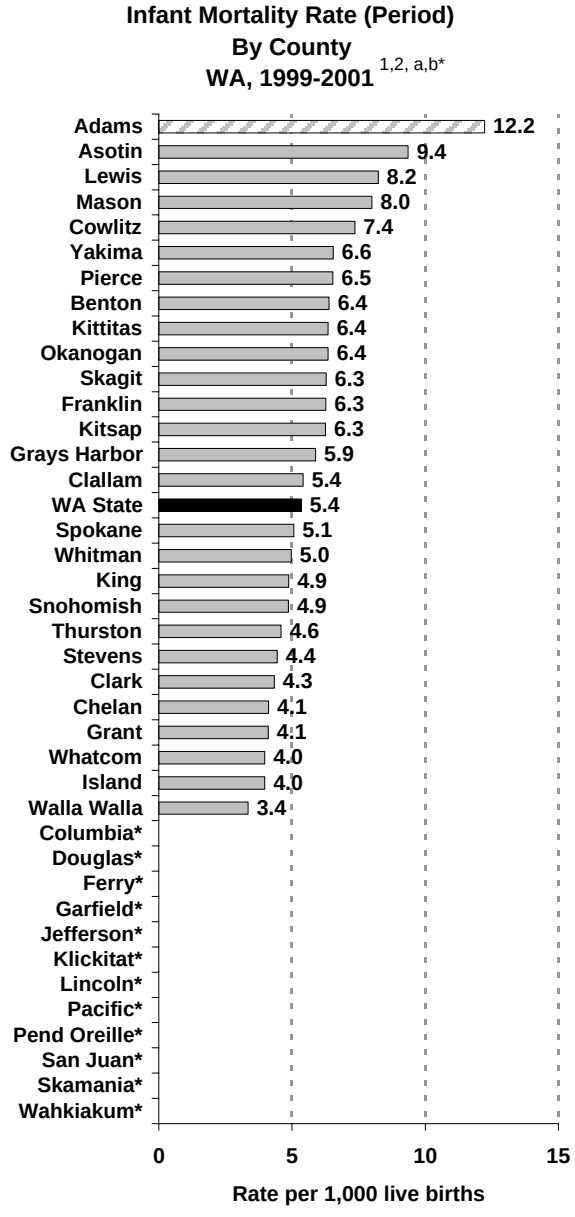
Infant Mortality

Definition: Infant mortality is the death of a child under one year of age. These deaths are often divided into two groupings: *neonatal* mortality (death of an infant within the first 27 days of life) and *Postneonatal* mortality (death of an infant of 28-364 days of age). Period rates are the number of deaths in a given year per 1,000 live births in the same year.

Key Findings

- **In 2001, 461 Washington State infants died in their first year of life. The infant mortality rate (IMR) for 2001 was 5.8 per 1,000 live births, compared to a 2001 national rate of 6.9 per 1,000 live births.[1,2,3,5]**
- **Washington's IMR has declined significantly over the past decade, from 7.8 per 1,000 live births in 1990 to 5.2 in 2000. In 2001, infant mortality increased to 5.8 per 1,000 live births. This trend is consistent with the national pattern.[1,2,3,5]**
- **The three leading causes of infant death in Washington in 2001 were congenital anomalies (26%), Sudden Infant Death Syndrome (SIDS) (13%), and short gestation/ low birth weight (11%). [1,2,3]**
- **Infant mortality rates were highest for Blacks, American Indian/ Alaska Natives, Non-Hispanics, teen mothers and mothers age forty and over, male infants, and Grant recipients.[1,2,3,6]**
- **The Healthy People 2010 objective is to reduce the infant mortality rate to no more than 4.5 per 1,000 live births.[4]**

County

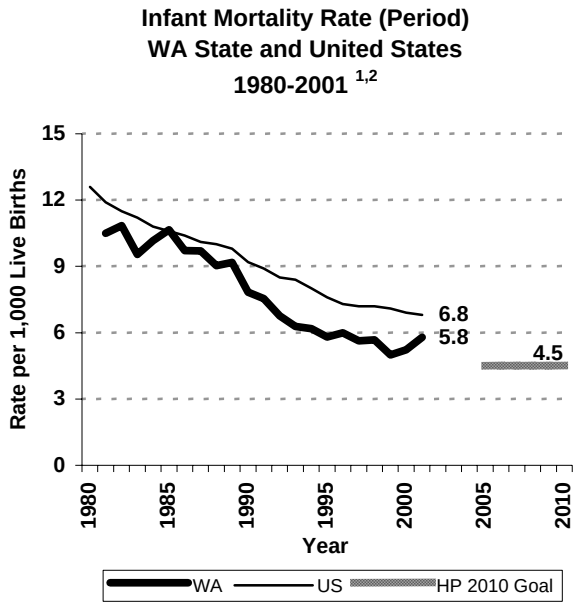


**County rates not calculated if less than 5 events*

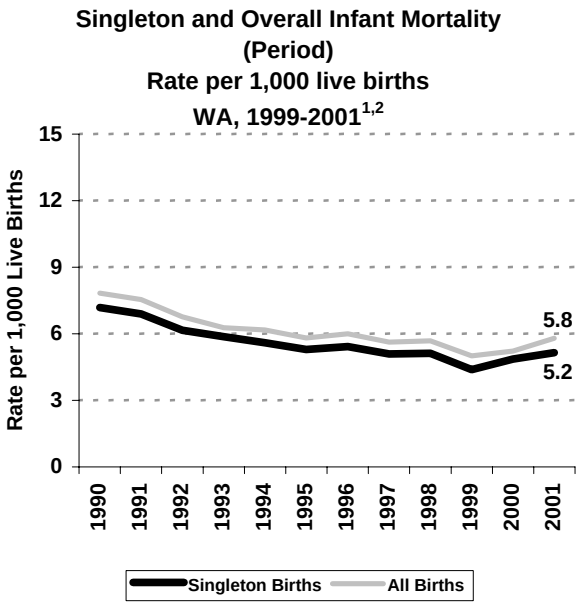
Significantly different from state rate

Infant Mortality (cont.)

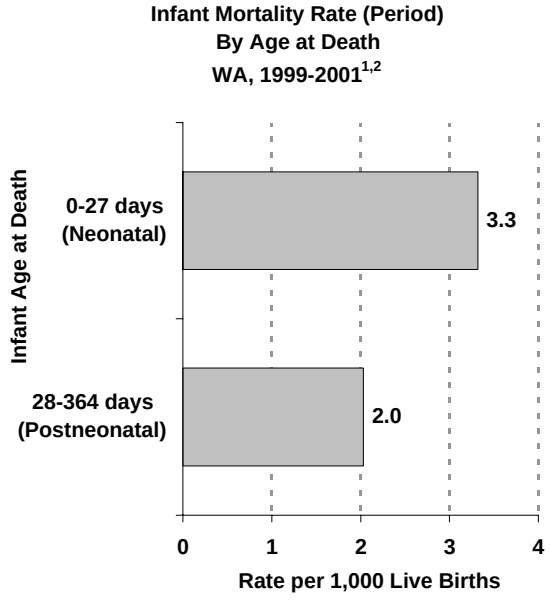
Trend



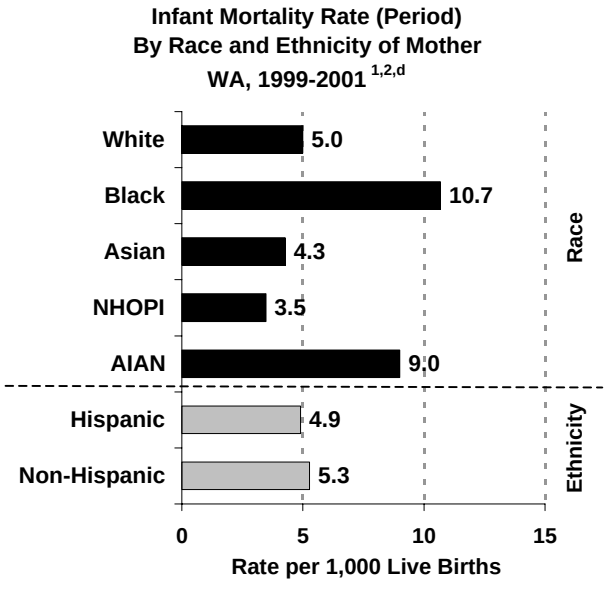
Singleton Infant Mortality



Infant Age

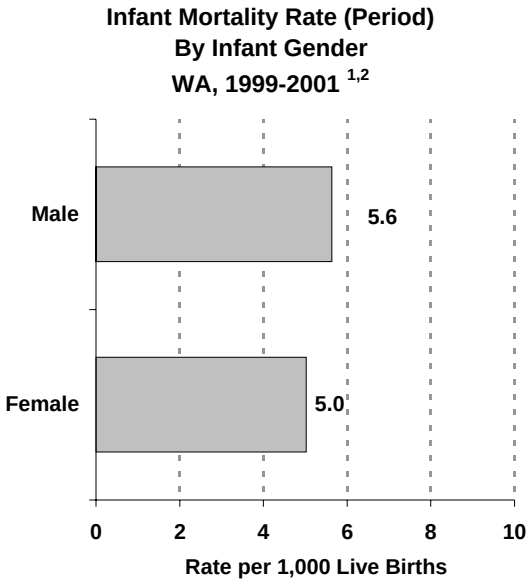


Race and Ethnicity

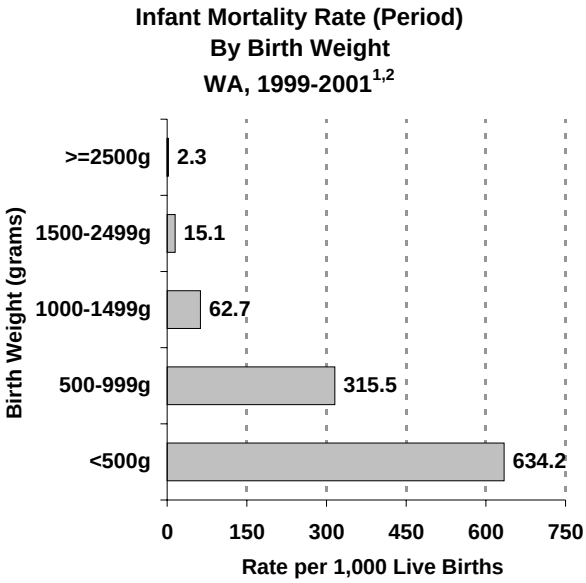


Infant Mortality (cont.)

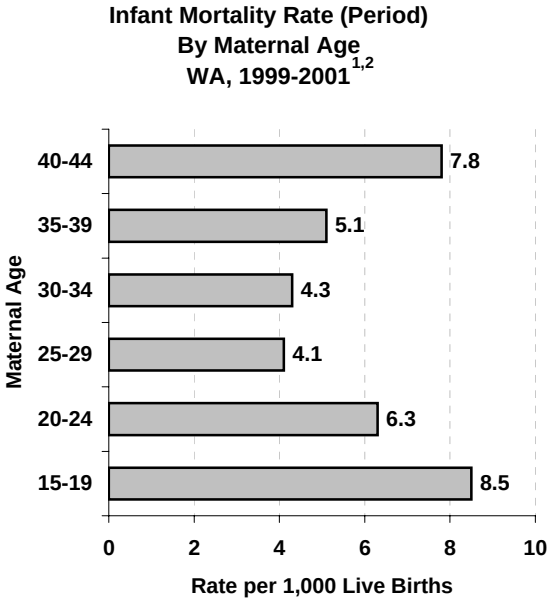
Infant Gender



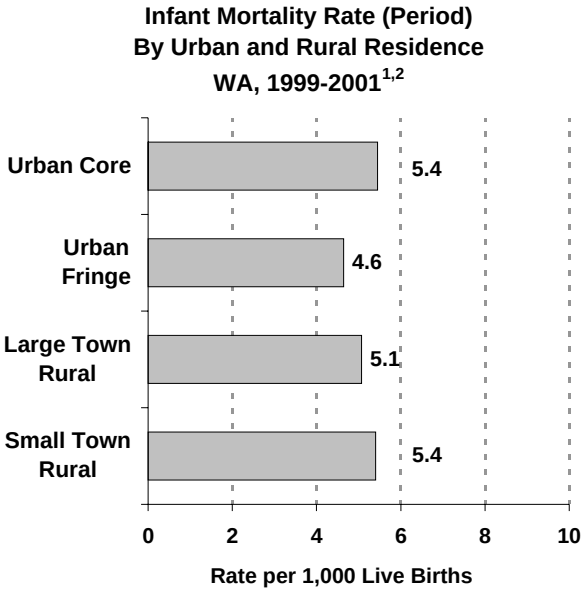
Birth Weight



Mother's Age

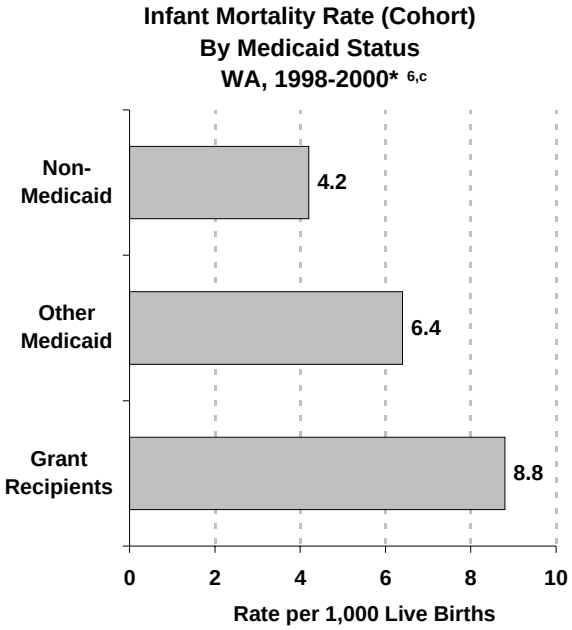


Rural and Urban Residence



Infant Mortality (cont.)

Medicaid Status



Medicaid women had either prenatal care or delivery paid by Medicaid. Medicaid women include those who are very low income and receive cash assistance (TANF) in addition to Medicaid* *[Grant Recipients]*** *and those who receive Medicaid with no cash assistance* ***[Other Medicaid]****.*

Data Sources

[1] Washington State death certificate data: Vital Statistics 2001, Washington State Department of Health, Center for Health Statistics, December 2002.

[2] Washington State birth certificate data: Vital Statistics 2001, Washington State Department of Health, Center for Health Statistics, December 2002.

[3] Analysis Software: Public Health - Seattle & King County, Epidemiology, Planning & Evaluation, Software for Public Health Assessment (VistaPHw), 1991-.

[4] Healthy People 2010: Understanding and Improving Health, US Department of Health and Human Services, Washington DC US Government Printing Office, 2000.

[5] National Vital Statistics Reports, Vol. 51, No. 5, March 14, 2003 .

[6] Cawthon L, Infant Mortality Rates for Washington Births by Year of Birth. Washington State Department of Social and Health Services, First Steps Database, 6/11/03.

Endnotes

[a] Significance was determined based on 95% Confidence Intervals.

[b] Period Infant Mortality Rate uses infant deaths in a given year as the numerator and infant births in the same year as the denominator.

[c] Cohort Infant mortality rates look at the experience of a birth cohort. The denominator includes all births in a specified year (cohort) and the numerator is the deaths that occurred to that cohort in the first year of life.

Intentional Injury Hospitalizations

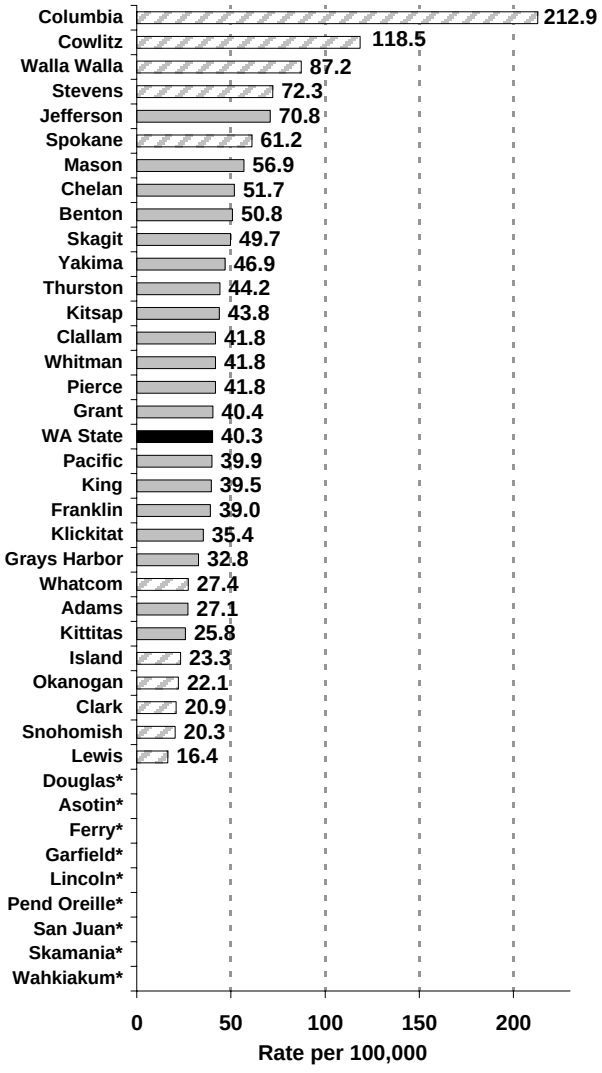
Definition: Intentional injury hospitalizations are those due to assault (ICD-9 codes E960-E969), or attempted suicide (ICD-9 codes E950-E959) as the primary E-code.[a] The data source is the Washington State Comprehensive Hospital Abstract Reporting System, (CHARS). Patients hospitalized more than once with the same diagnosis are counted as separate incidents.

Key Findings

- **In 2001, there were 700 nonfatal hospitalizations due to intentional injury for Washington state residents ages 0-19, for a rate of 41.3 per 100,000. This represents a 31% decline from the 1989 rate of 59.8 per 100,000 [1,2]**
- **In 2001, 401 Washington adolescents ages 15-19 (or 92.2 per 100,000) were hospitalized after a suicide attempt.[1]**
- **The intentional injury hospitalization rates for 1999-2001 were highest in Washington children ages 15-19 years and in infants.[1]**
- **From 1999-2001, Washington females ages 0-19 had a significantly higher intentional injury hospitalization rate than males.[1]**
- **While the leading causes of intentional injury hospitalizations differ by age, for all Washington children ages 0-19 the most common causes for nonfatal intentional injury hospitalizations were poisoning, cutting/piercing, and struck by/against (which includes injuries caused by being struck by an object or person).[3]**

County

Intentional Injury Hospitalization Rate
Ages 0-19
By County
WA, 1999-2001*[1,a]

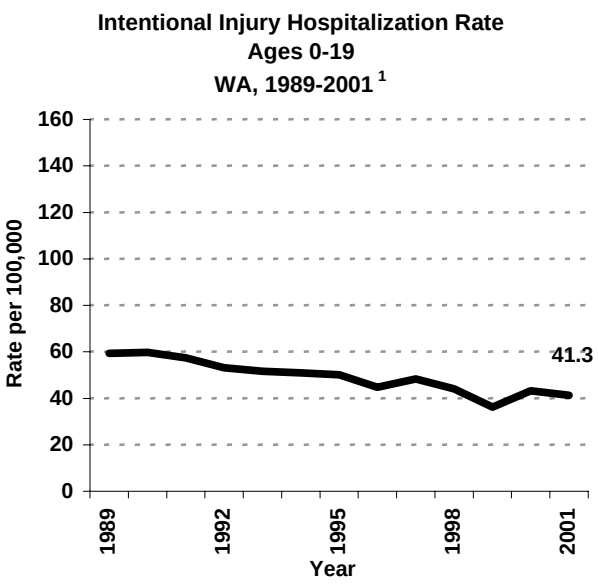


**County rate not calculated if less than 5 events.*

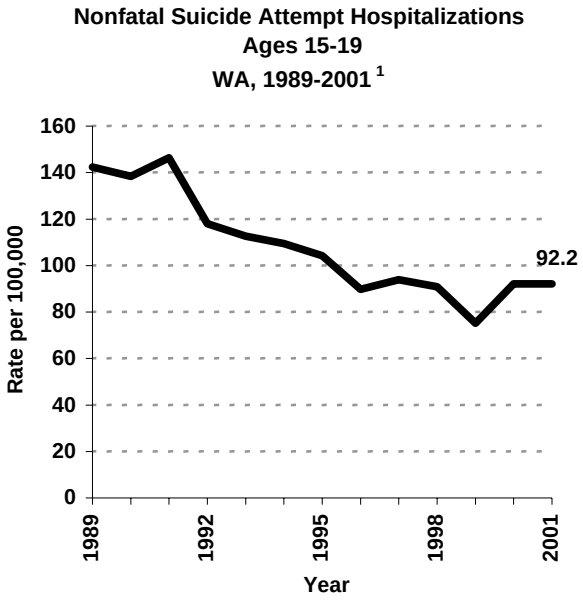
Significantly different from state rate

Intentional Injury - Hospitalizations (cont.)

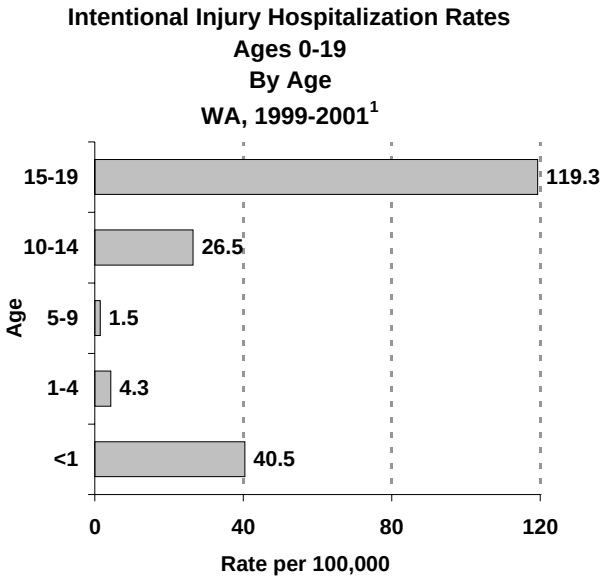
Time Trend



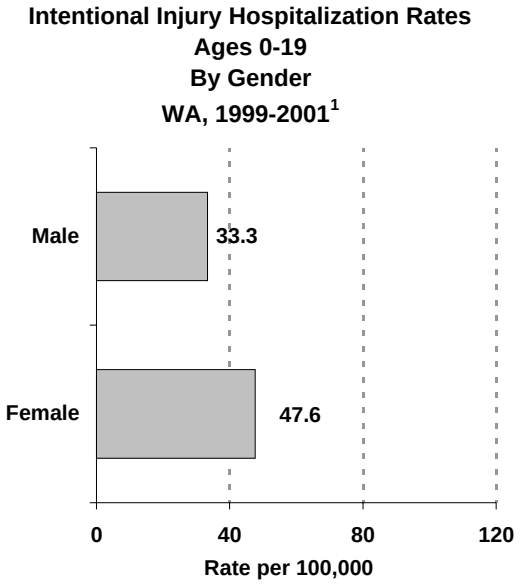
Suicide Attempts: 15 to 19 year olds



Age



Gender



Intentional Injury - Hospitalizations (cont.)

Leading Causes of Nonfatal Intentional Injury Hospitilizations 1997-2001, WA Children Ages 0-19 By Age[3]

Rank	Causes			
	Ages < 10*	**Ages 10-14**	**Ages 15-19**	**Ages 0-19**
1st	Struck by or against an object/ person	Poisoning	Poisoning	Poisoning
2nd	Cut/ pierce	Cut/ pierce	Cut/ pierce	Cut/ pierce
3rd	Firearm	Struck by or against an object/ person	Struck by or against an object/ person	Struck by or against an object/ person

**Age groups not broken down further due to small numbers of hospitalizations.*

Data Sources

[1] Comprehensive Hospital Abstract Reporting System (CHARS), Washington State Department of Health, 1987-2001

[2] Analysis Software: Public Health - Seattle & King County, Epidemiology, Planning & Evaluation, Software for Public Health Assessment (VistaPHw), 1991-.

[3] Injury Prevention and Safety Program, Washington State Department of Health: http://www.doh.wa.gov/cfh/Injury/Tables_update.htm .

Endnotes

[a] Significance was determined based on 95% Confidence Intervals.

Intentional Injury Mortality

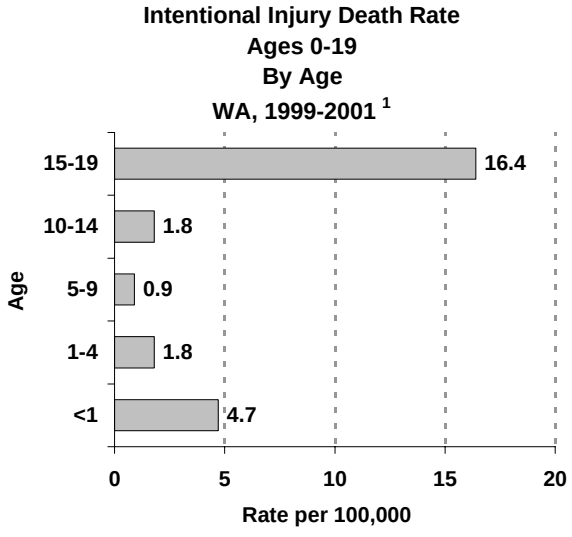
Definition: Intentional injury deaths are due to homicides and suicides.[a]

Key Findings

- **In 2001, there were 76 deaths due to intentional injury for Washington state residents ages 0-19 (40 suicides and 36 homicides), resulting in an intentional injury mortality rate of 4.5 per 100,000 children ages 0-19 (or 2.4 for suicides, and 2.1 for homicides).[1,2]**
- **From 1999-2001, youth ages 15-19 had the highest intentional injury death rates (16.4 per 100,000) of all Washington children followed by infants (4.7 per 100,000).[1]**
- **From 1999-2001, males had intentional injury death rates nearly three times greater than females. Intentional injury death rates were higher in American Indian/ Alaska Native and Black children compared to other races.[1,b]**
- **Firearms were the most frequently used mechanism for intentional injury deaths, followed by suffocation and poisoning.[3]**
- **Thirty-five youth ages 15-19 committed suicide in 2001. The suicide rate for Washington youths ages 15-19 was 8.1 per 100,000, down from 12.6 per 100,000 in 1990, although the difference is not statistically significant.[1,b]**
- **Washington's local Child Death Review (CDR) teams reviewed 127 intentional injury deaths of children ages 0-17 from 1999-2001 and concluded that 86 (68%) of these deaths were preventable.[4]**
- **For the whole population, the Healthy People 2010 goal is to reduce suicides to no more than 5.0 per 100,000 population and homicides to no more than 3.0 per 100,000.[5]**

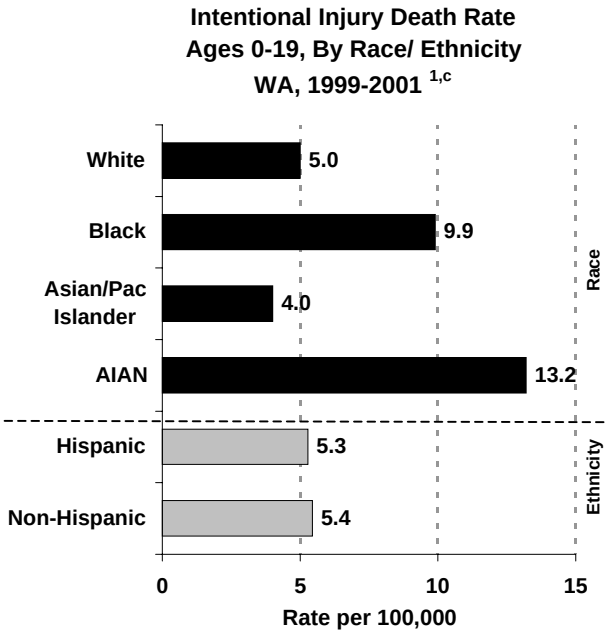
Time Trend

Age

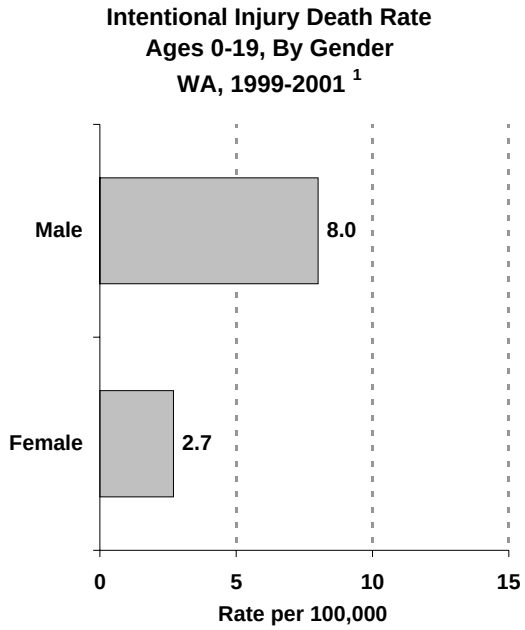


Intentional Injury Mortality (cont.)

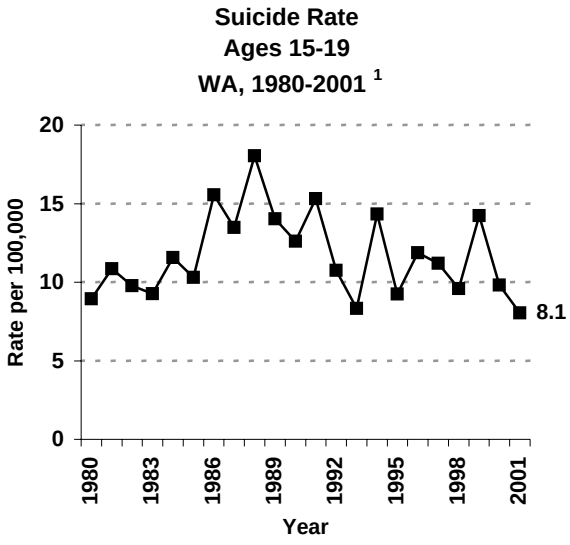
Race and Ethnicity



Gender



Block Grant Measure:
Suicides: 15 to 19 year olds



Leading Causes of Intentional Injury Deaths WA Children, Ages 0-19,1999-2001[3]	
Rank	**Causes**
1st	Firearms (N=135)
2nd	Suffocation (N=54)
3rd	Poisoning (N=17)
4th	Cut/ Pierce (N=15)

Intentional Injury Mortality (cont.)

Data Sources

[1] Washington State death certificate data: Vital Statistics 2001, Washington State Department of Health, Center for Health Statistics, December 2002.

[2] Analysis Software: Public Health - Seattle & King County, Epidemiology, Planning & Evaluation, Software for Public Health Assessment (VistaPHw), 1991-.

[3] Injury Prevention and Safety Program, Washington State Department of Health: http://www.doh.wa.gov/cfh/Injury/Tables update.htm .

[4] Data from the Washington State Child Death Review Database, MCH Assessment Section, Washington State Department of Health,1999-2001.

[5] Healthy People 2010: Understanding and Improving Health, US Department of Health and Human Services, Washington DC US Government Printing Office, 2000.

Endnotes

[a] Intentional self-harm (suicide) for years after 1998 include ICD-10 codes X60-X84 and Y87.0. Assault (homicide) includes ICD-10 codes X85-Y09 and Y87.1. For years 1980-1998, intentional self-harm include ICD-9 codes E950-E959, and assault include ICD-9 codes E960-E969.Comparability ratio (used to enable comparison of ICD9 and ICD10 coded data) for intentional injury mortality was 1.00 (SE 0.0005 for suicides and 0.0006 for homicides).

[b] Significance was determined based on 95% Confidence Intervals.

[c] Population denominators for non-Hispanics are estimated by subtracting the number of Hispanics from the total population and may include unknowns.

[d] AIAN - American Indian Alaskan Native

Low Birth Weight for Singleton Births

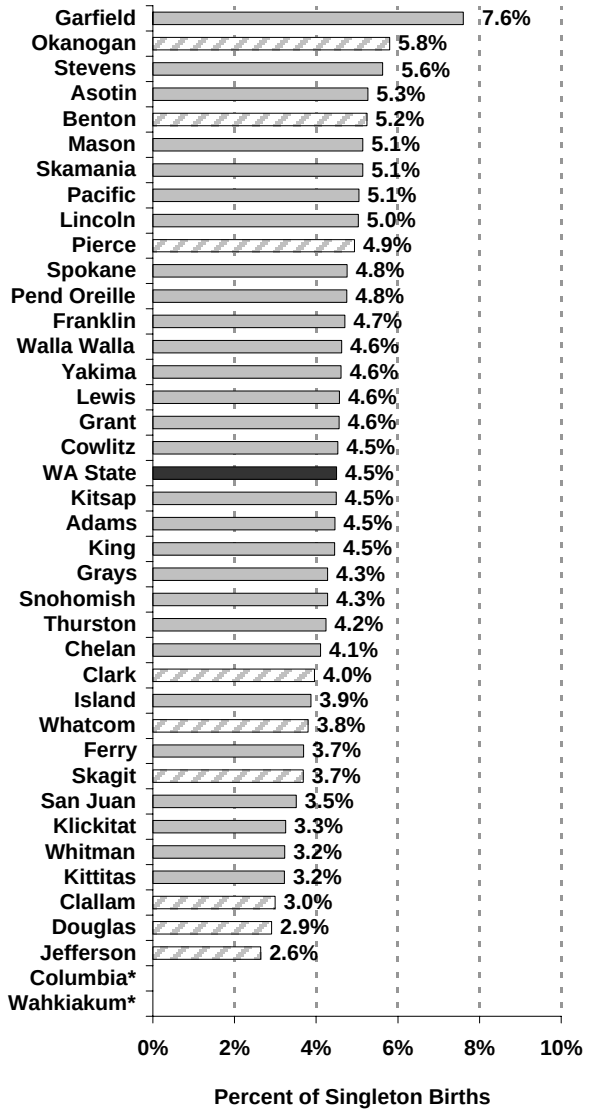
Definition: Low birth weight is a newborn birth weight less than 2,500 grams (5 lbs. 8 oz.). The analysis in this chapter is limited to singleton (one baby) births.

Key Findings

- **Low birth weight (LBW) is a major contributor to infant mortality and morbidity and care of the LBW infant is costly. These data are limited to singleton births in order to explore factors other than plurality (multiple births) which may be influencing LBW trends.**
- **In 2001, the low birth weight rate for singletons was 4.5%, representing 3,454 births in Washington State. The overall Washington LBW (which includes multiple births) was 5.8% or 4,588 births in 2001. In 2001, the national singleton LBW rate was 6.0% and overall LBW rate was 7.7%.[1,2,3]**
- **While the overall Washington LBW rate increased significantly from 5.3% in 1990 to 5.8% in 2001, the singleton LBW rate has not changed significantly from the 1990 rate of 4.3%.[1,a]**
- **Singleton LBW births were significantly higher among Black women compared to women of other races and among women ages 15-19 and 40-44 compared to other age groups.[1,a]**
- **The national Healthy People 2010 objective is to reduce the overall LBW rate to no more than 5.0%.[5]**

County

Low Birth Weight for Singletons By County, WA, 1999-2001[1,a]*

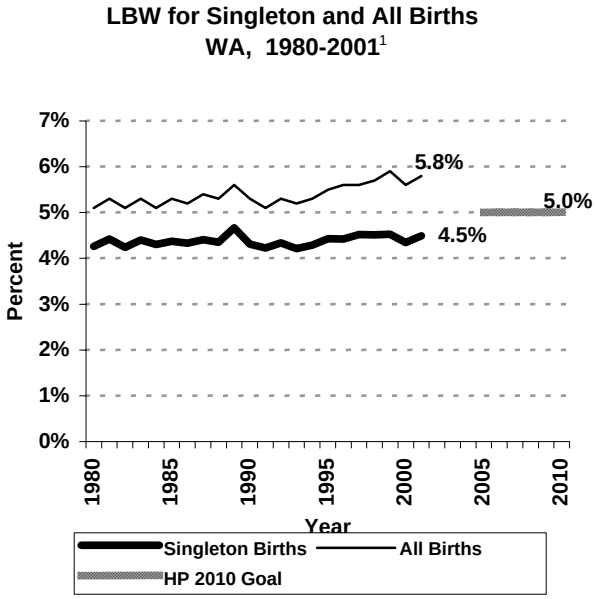


**County rate not calculated if less than 5 events.*

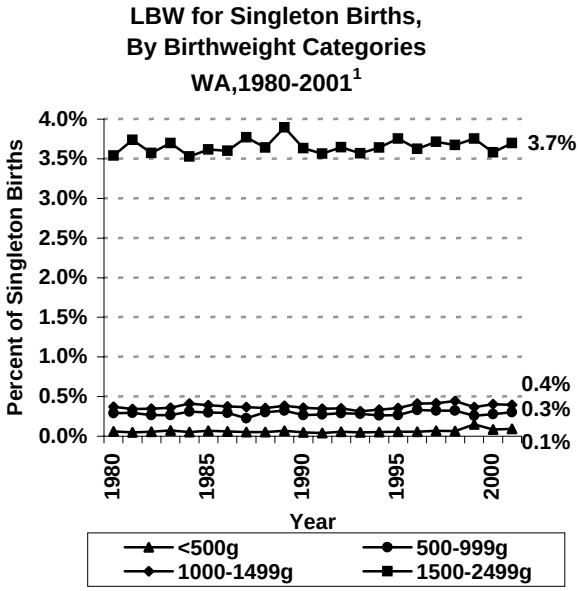
Significantly different from state rate

Low Birth Weight for Singleton Births (cont.)

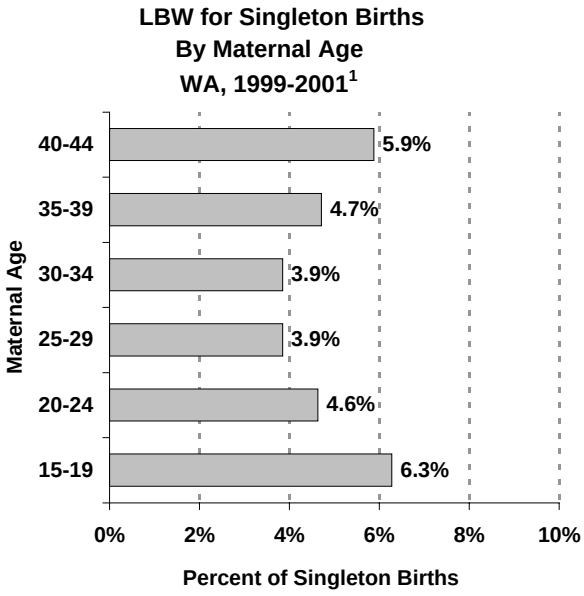
Time Trend



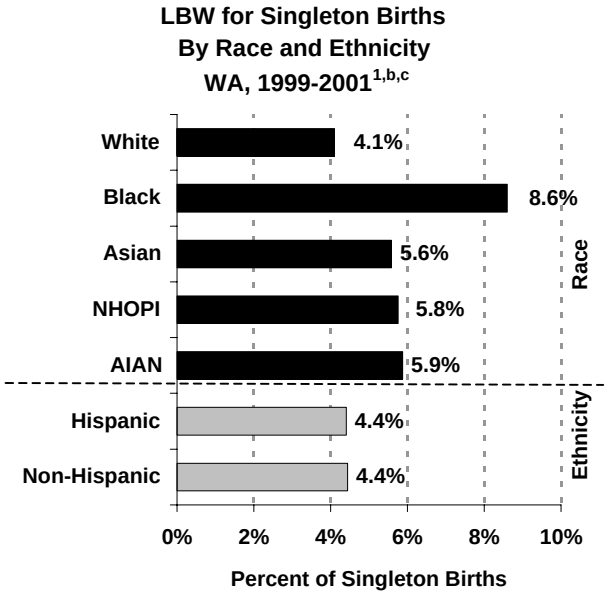
Birth Weight Trend



Age

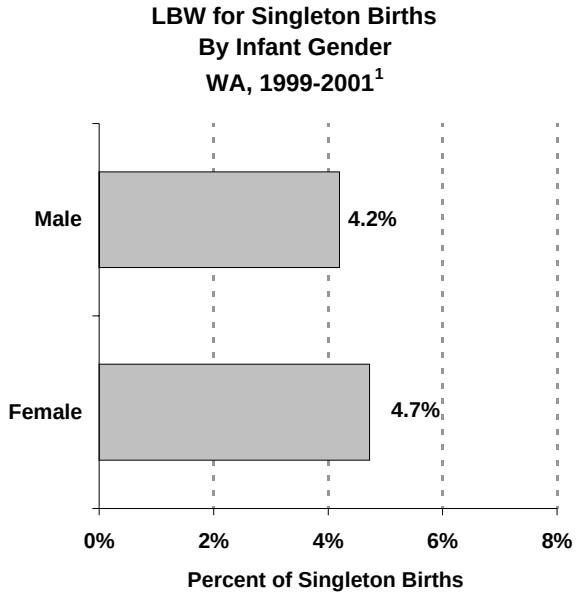


Race and Ethnicity

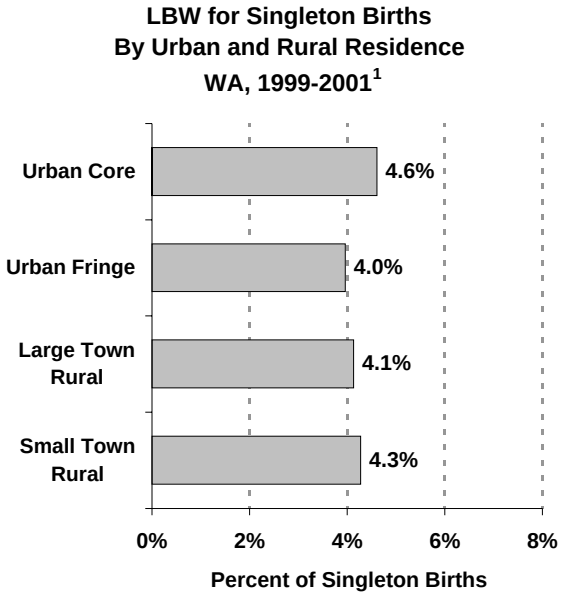


Low Birth Weight for Singleton Births (cont.)

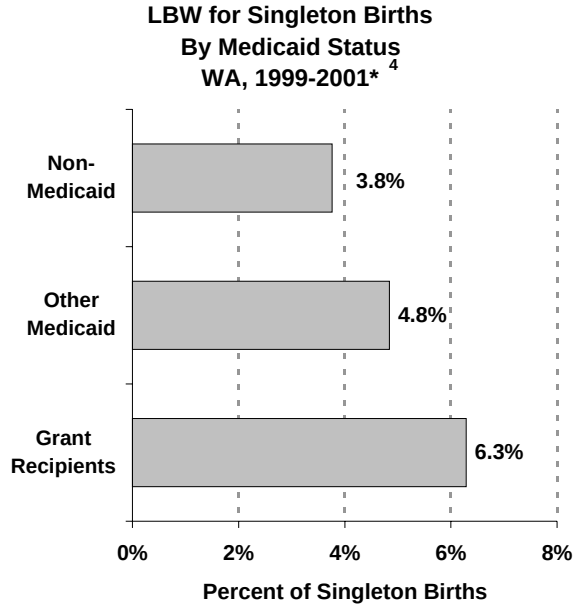
Gender



Rural and Urban Residence



Medicaid Status



Medicaid women had either prenatal care or delivery paid by Medicaid. Medicaid women include those who are very low income and receive cash assistance (TANF) in addition to Medicaid* *[Grant Recipients]*** *and those who receive Medicaid with no cash assistance* ***[Other Medicaid]****.*

Low Birth Weight for Singleton Births (cont.)

Data Sources

[1] Washington State birth certificate data: Vital Statistics 2001, Washington State Department of Health, Center for Health Statistics, December 2002.

[2] Analysis Software: Public Health - Seattle & King County, Epidemiology, Planning & Evaluation, Software for Public Health Assessment (VistaPHw), 1991-.

[3] Births: Final data for 2001. National Vital Statistics Report; Vol 52 No 2. Hyattsville, Maryland: National Center for Health Statistics. 2002.

[4] Cawthon, L. Characteristics of Women Who Gave Birth in Washington State, Washington State Department of Social and Health Services, First Steps Database, 10/22/02.

[5] Department of Health and Human Services (US). Healthy People 2010: Understanding and Improving Health. 2nd edition. Washington, DC: US Government Printing Office; November 2000.

Endnotes

[a] Significance was determined based on 95% Confidence Intervals.

[b] AIAN - American Indian Alaskan Native

[c] NHOPI - Native Hawaiian Other Pacific Islander

Oral Health

Definition: Oral health status includes common oral and craniofacial diseases and conditions such as dental caries and periodontal disease. In this chapter, dental caries is used as a measure of poor oral health. Dental caries is an infectious disease caused by Streptococcus mutans. Rampant caries means 7+ teeth decayed, missing or filled.

Key Findings

- **Oral health is an essential component of health and dental caries is the single most common chronic disease of childhood. Dental caries are caused by an infectious disease process that nationally affects about 80% of all children by age 18.[1,2]**
- **Based on data from Washington's Smile Survey 2000, about 21% of 2nd-3rd graders had untreated decay and 15% were found to have rampant (7+) caries. Asians, Pacific Islanders, Hispanics, and American Indian/ Alaska Natives had higher rates of rampant caries.[1]**
- **Low income children in the 2000 Smile survey were twice as likely to have rampant caries as other children. Children in rural communities were at higher risk for dental caries and rampant caries.[1]**
- **Sealants can reduce the development of caries. Overall, about 47% of 2nd-3rd graders surveyed had sealants. Blacks, Asians and Pacific Islanders were least likely to have sealants.[1]**
- **Research has shown that poor oral health during pregnancy can lead to dental caries in infants and young children. PRAMS data for 2000 show 27% of mothers who were Grant Recipients went to the dentist during their pregnancy compared to 47% for Other Medicaid recipients and 56% of non-Medicaid mothers.[3,a]**
- **Data from the Centers for Disease Control and Prevention indicate that about 58% of the Washington State population has access to optimally fluoridated water through public water systems, an increase from 53% in 1992.[4]**
- **The 2010 National Healthy People targets are to reduce the proportion of children ages 6-8 with untreated dental decay in primary and permanent teeth to no more than 21% and that at least 50% of all children have dental sealants in place.[2]**

Oral Health Status of Washington's 2nd & 3rd Grade Children[1]

Oral Health Status Indicator	%	95% Confidence Intervals
Percent with decay experience - primary and/or permanent teeth	56	(54-57)
Percent with decay experience - permanent teeth only	15	(14-17)
Percent with rampant decay (or a history of)	15	(14-17)
Percent with untreated decay	21	(19-23)
Percent needing treatment	22	(20-23)
Percent needing urgent treatment	4	(3-4)
Percent with sealants	47	(45-49)
Mean number of cavities in those children with decay	2.4	-

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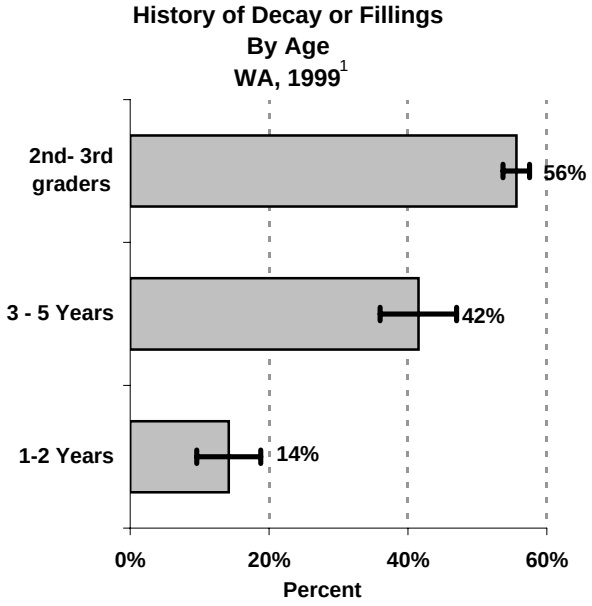
- **Sealants can reduce the development of caries. Overall, about 47% of 2nd-3rd graders surveyed had sealants. Blacks, Asians and Pacific Islanders were least likely to have sealants.[1]**
- **Research has shown that poor oral health during pregnancy can lead to dental caries in infants and young children. PRAMS data for 2000 show 27% of mothers who were Grant Recipients went to the dentist during their pregnancy compared to 47% for Other Medicaid recipients and 56% of non-Medicaid mothers.[3,a]**
- **Data from the Centers for Disease Control and Prevention indicate that about 58% of the Washington State population has access to optimally fluoridated water through public water systems, an increase from 53% in 1992.[4]**
- **The 2010 National Healthy People targets are to reduce the proportion of children ages 6-8 with untreated dental decay in primary and permanent teeth to no more than 21% and that at least 50% of all children have dental sealants in place.[2]**

Oral Health Status of Washington's 2nd & 3rd Grade Children[1]

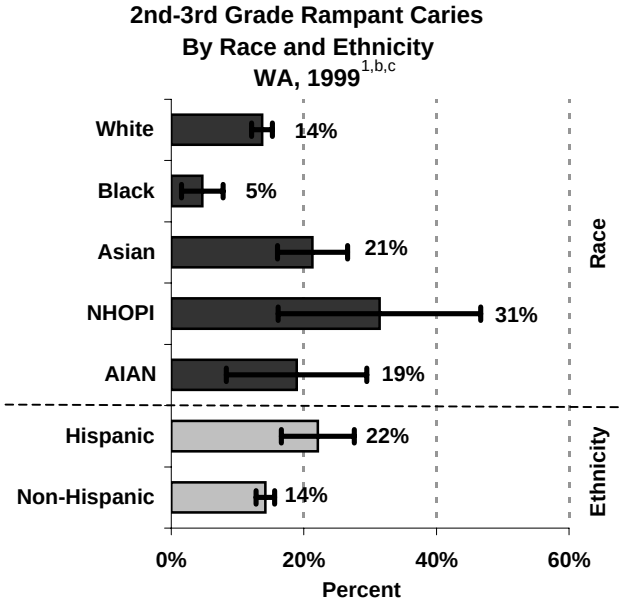
Oral Health Status Indicator	%	95% Confidence Intervals
Percent with decay experience - primary and/or permanent teeth	56	(54-57)
Percent with decay experience - permanent teeth only	15	(14-17)
Percent with rampant decay (or a history of)	15	(14-17)
Percent with untreated decay	21	(19-23)
Percent needing treatment	22	(20-23)
Percent needing urgent treatment	4	(3-4)
Percent with sealants	47	(45-49)
Mean number of cavities in those children with decay	2.4	-

Oral Health (cont.)

Age



Race and Ethnicity



Data Sources

[1] Smile Survey 2000, Washington State Department of Health, May 2001.

[2] Department of Health and Human Services (US). Healthy People 2010: Understanding and Improving Health. 2nd edition. Washington, DC: US Government Printing Office; November 2000.

[3] Washington Pregnancy Risk Assessment Monitoring System (PRAMS), 2000.

[4] Populations Receiving Optimally Fluoridated Public Drinking Water-United States 2000, Centers for Disease Control and Prevention. February 2002.

Endnotes

[a] The source for the Medicaid designations used in PRAMS is the Washington State Department of Social and Health Services, First Steps Database. Medicaid women had either prenatal care or delivery paid by Medicaid. Medicaid women include those who are very low income and receive cash assistance (TANF) in addition to Medicaid (Grant Recipients) and those who receive Medicaid with no cash assistance (Other Medicaid).

[b] AIAN - American Indian Alaskan Native

[c] NHOPI - Native Hawaiian Other Pacific Islander

Perinatal Behaviors

Definition: Self-reported data from the 1998-2000 Pregnancy Risk Assessment Monitoring System (PRAMS) on maternal behaviors and experiences before, during, and after pregnancy among Washington State residents who delivered live born infants. Perinatal behaviors include pre-pregnancy multivitamin use, breastfeeding, sleep position of infant, and postpartum birth control.

Key Findings

Multi-Vitamin Awareness and Use

- **From 1997-1999, approxiamtely 73% of mothers reported having heard or read that folic acid could prevent some birth defects.[1]**
- **In 2000, PRAMS began asking mothers about taking multivitamins. In that year, an estimated 54% of mothers responded they did not take multi-vitamins (MVI) in the month before their pregnancy. Mothers who were least likely to take multi-vitamins were younger, Grant recipients, or other Medicaid recipients.[1]**
- **American Indian/ Alaska Natives, Blacks, and Asians were more likely than other races to report no multivitamins use prior to pregnancy and Hispanics were more likely than non-Hispanics to report no MVI use. [1]**
- **The Healthy People 2010 objective is for 80% of pregnancies to begin with an optimal folic acid level.[2]**

Breastfeeding

- **From 1998-2000, about 67% of mothers breastfed their infants for 8 or more weeks while another 9% of mothers breastfed 4-7 weeks.[1]**
- **Mothers under age 20 (about 41%) were significantly less likely to breastfeed for 8+ weeks than other age groups, while mothers age 35 and older were significantly more likely to breastfeed (about 81%) that length of time than women under age 30. [1,a]**
- **Black and American Indian/Alaska Native mothers were less likely to breastfeed 8 or more weeks than mothers of other races.[1]**
- **The Healthy People 2010 objective is for 75% of mothers to breastfeed in the early postpartum period.[2]**

Sleep Position

- **During 1998-2000,an estimated 66% of mothers said that they placed infants on their backs when they put them to sleep.[1]**
- **Black and Hispanic mothers were less likely than other mothers to place their babies to sleep on their backs. Mothers not receiving Medicaid were significantly more likely to place their babies on their back when they put them to sleep (about 71%) compared to Grant recipients (about 55%) and other Medicaid recipients (about 61%).[1,a]**
- **Women age thirty and older were more likely than younger women to report they generally placed their infants on their backs to sleep.[1]**
- **The Healthy People 2010 objective is for 70% of healthy full-term babies to be put down to sleep on their backs.[2]**

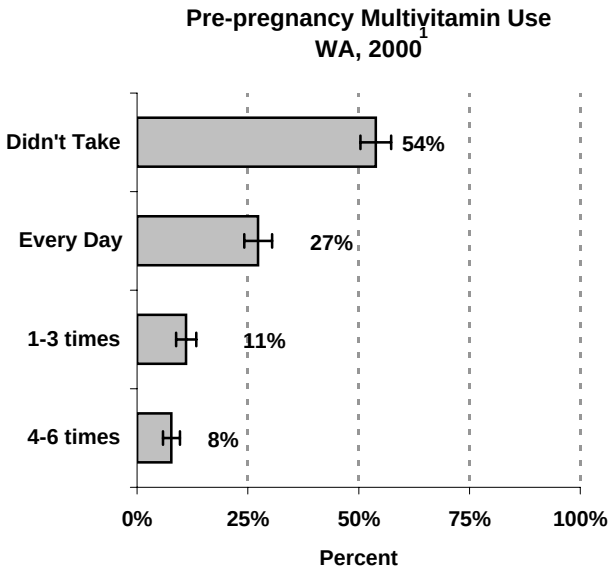
Postpartum Birth Control

- **Nearly 80% of mothers were using birth control when surveyed 2-5 months postpartum.[1]**
- **Women ages less than 25 were more likely than older women to report using postpartum birth control. White, American Indian/ Alaska Native, and Black women were more likely than other races to report using postpartum birth control.[1]**
- **There was no significant difference in postpartum birth control use between Grant recipients (about 76%), other Medicaid recipients (about 81%) and mothers not receiving Medicaid (about 79%).[1]**

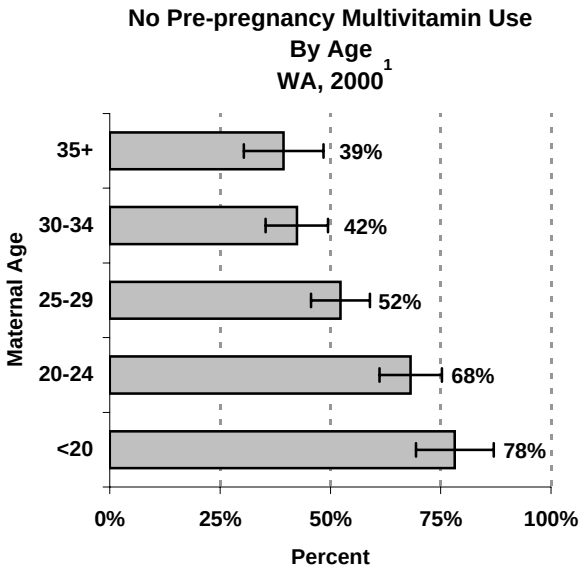
Perinatal Behaviors (cont.)

Multi-Vitamin Awareness and Use

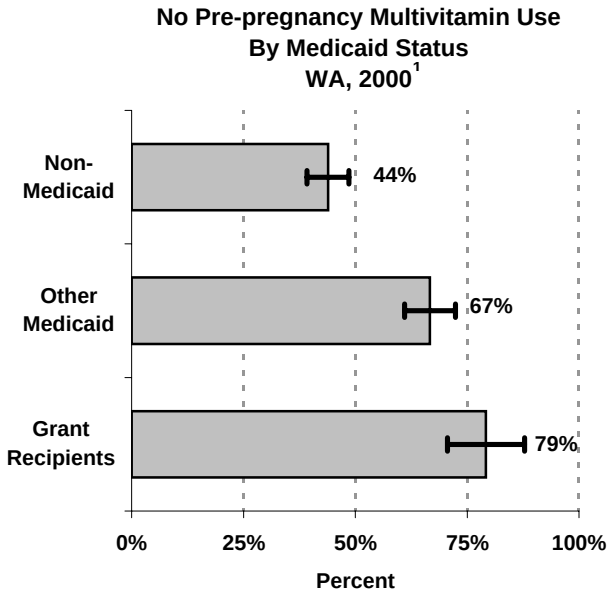
Overall



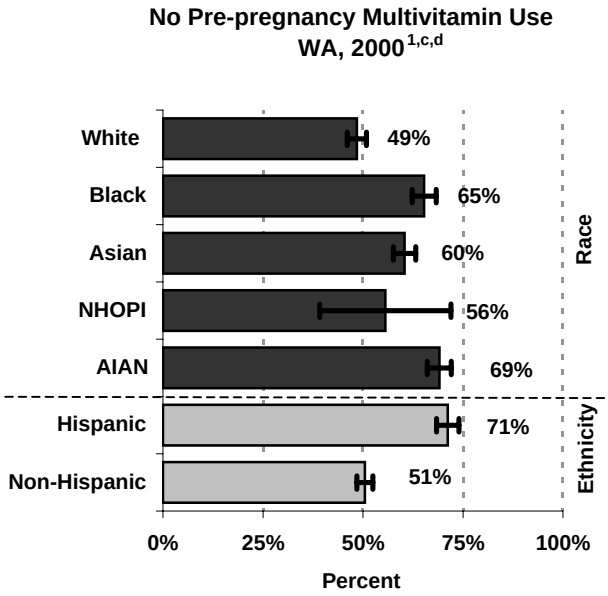
Maternal Age



Medicaid Status*[,b]



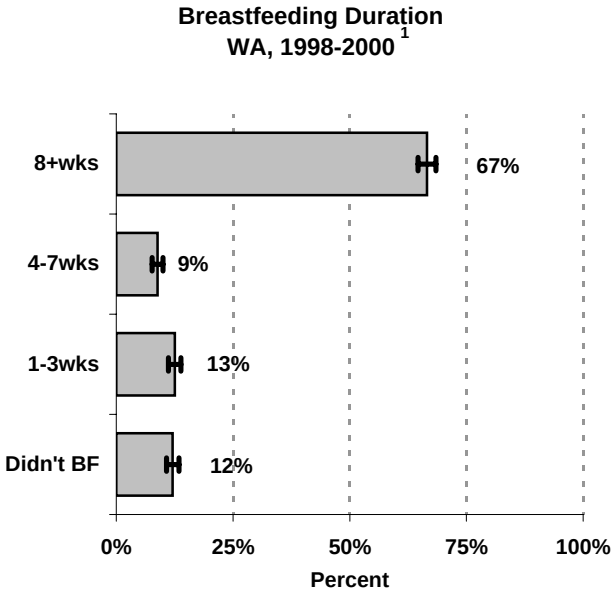
Race and Ethnicity



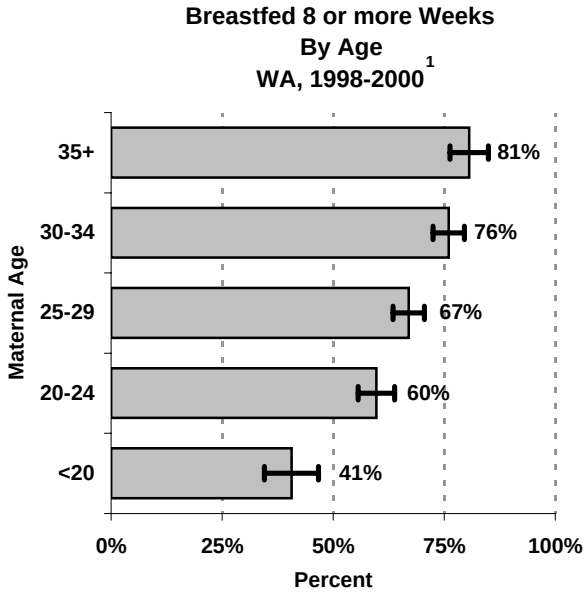
Medicaid women had either prenatal care or delivery paid by Medicaid. Medicaid women include those who are very low income and receive cash assistance (TANF) in addition to Medicaid **[Grant Recipients] and those who receive Medicaid with no cash assistance **[Other Medicaid]**.*

Breast Feeding Duration

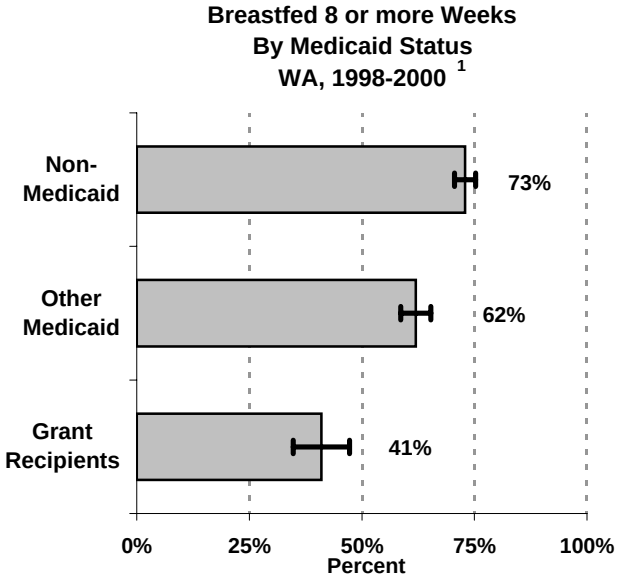
Overall



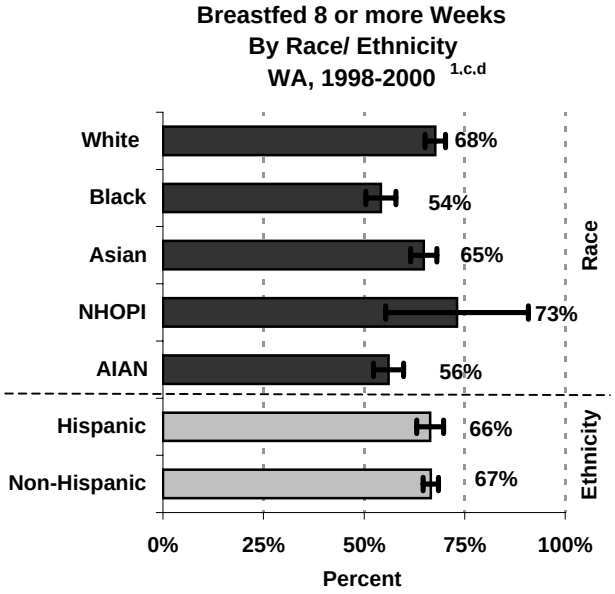
Maternal Age



Medicaid Status*,[b]



Race and Ethnicity



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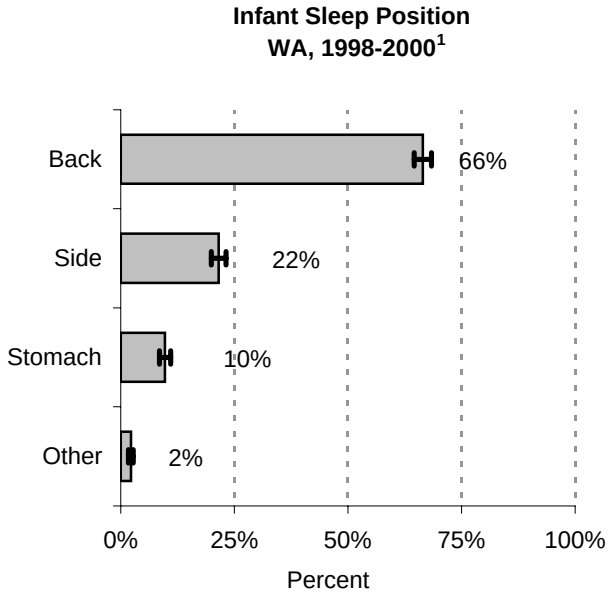
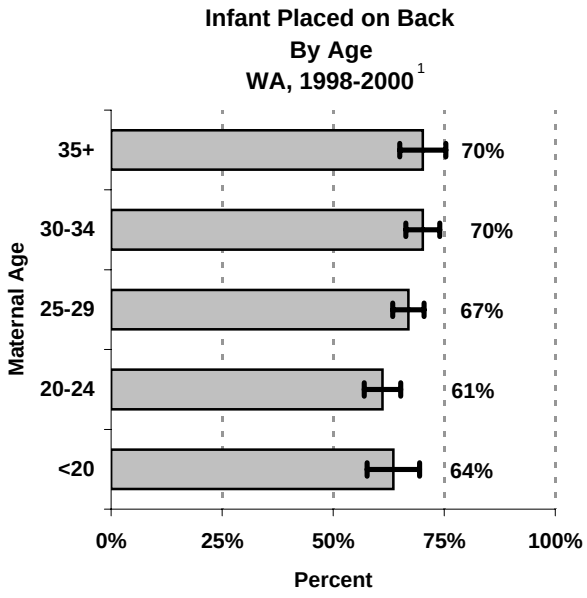
Perinatal Behaviors (cont.)

Sleep Position

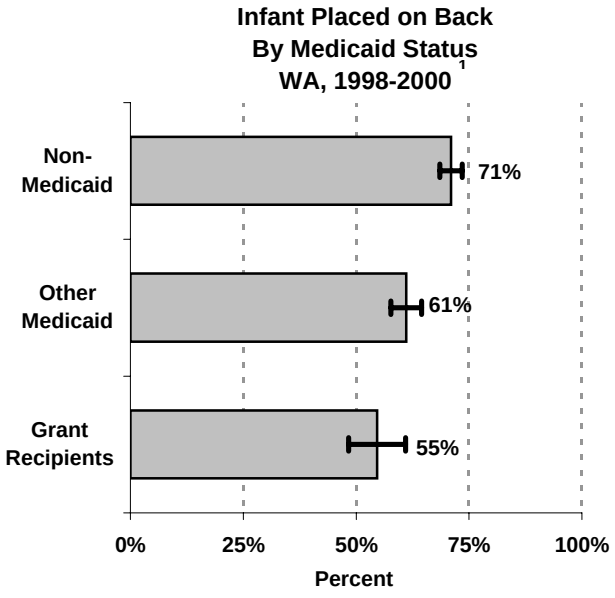
Overall



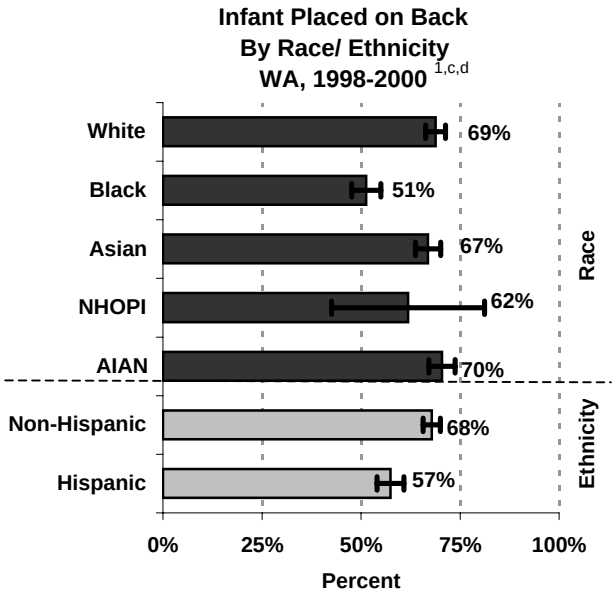
Maternal Age



Medicaid Status*,[b]



Race and Ethnicity



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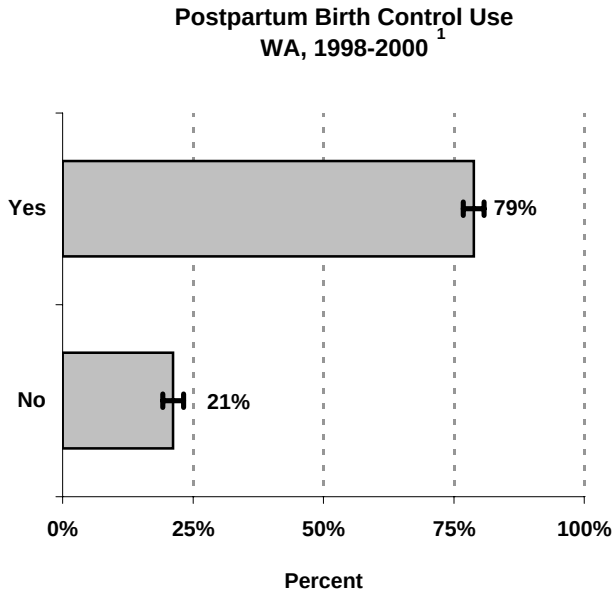
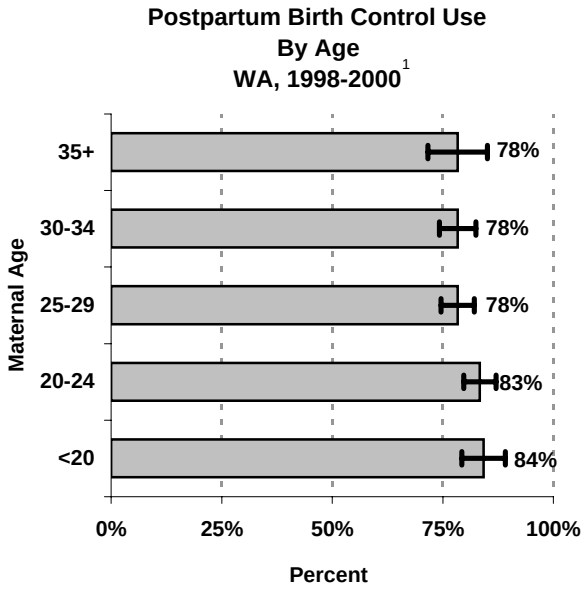
Postpartum Birth Control

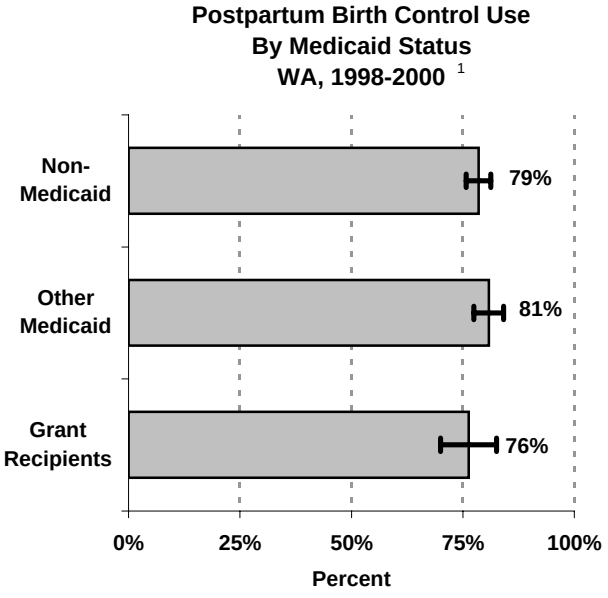
Overall



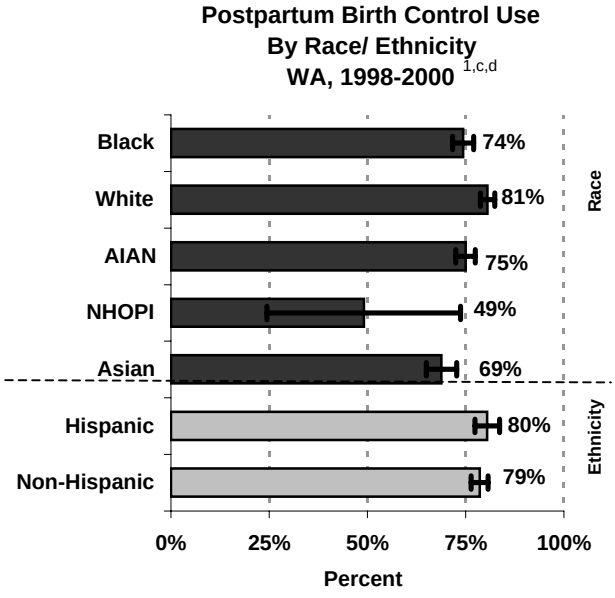
Maternal Age



Medicaid Status*,b



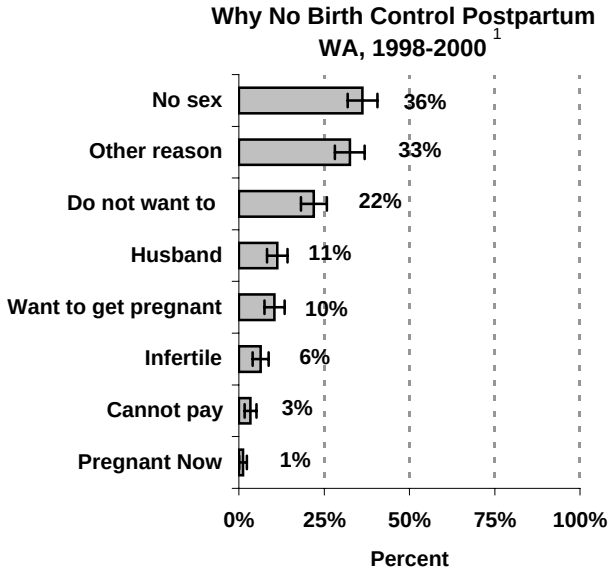
Race and Ethnicity



Medicaid women had either prenatal care or delivery paid by Medicaid. Medicaid women include those who are very low income and receive cash assistance (TANF) in addition to Medicaid* *[Grant Recipients]*** *and those who receive Medicaid with no cash assistance* ***[Other Medicaid]****.*

Perinatal Behaviors (cont.)

Reasons for No Birth Control Postpartum



Data Sources

[1] Pregnancy Risk Assessment Monitoring System (PRAMS), 1998 - 2000.

[2] Department of Health and Human Services (US). Healthy People 2010: Understanding and Improving Health. 2nd edition. Washington, DC: US Government Printing Office; November 2000.

Endnotes

[a] Significance is based on 95% Confidence Intervals.

[b] The source for the Medicaid designations used in PRAMS is the Washington State Department of Social and Health Services, First Steps Database.

[c] AIAN American Indian Alaskan Native

[d] NHOPI - Native Hawaiian Other Pacific Islander

Prenatal Care

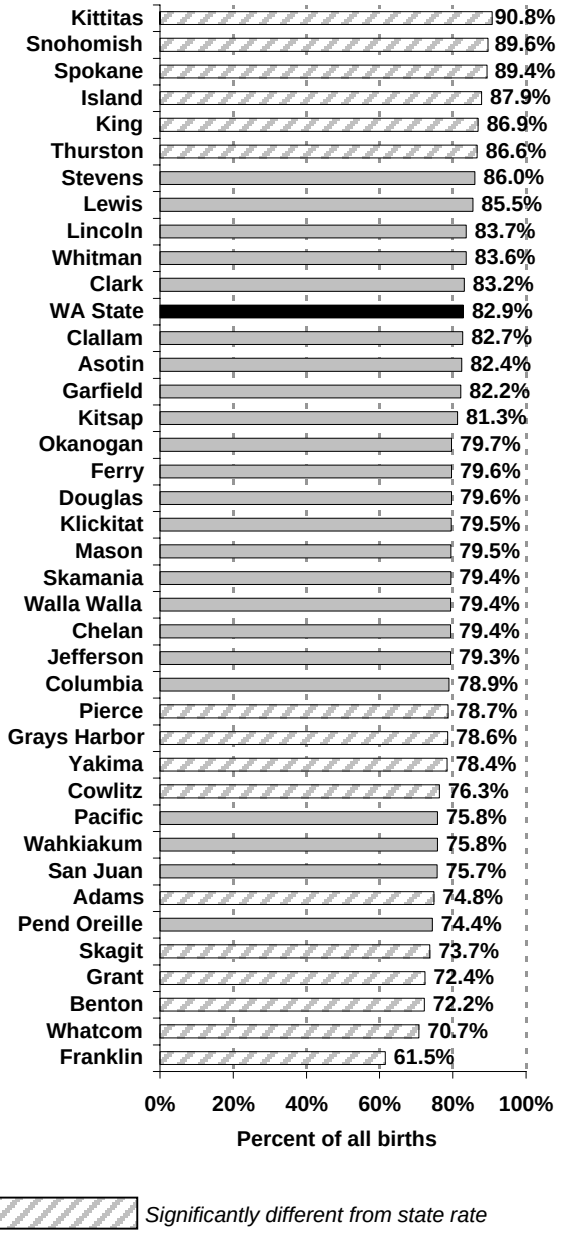
Definition: Prenatal care is comprehensive medical care provided for the mother and fetus. Services include screening and treatment for medical conditions, and identification and interventions for behavioral risk factors asociated with poor birth outcomes. First trimester is the first three months of pregnancy. These data include only women with a live birth.

Key Findings

- **Early and continuous prenatal care is considered the best strategy for improving the long-term health of the mother and preventing adverse birth outcomes.**
- **In 2001, an estimated 83.2% of Washington state pregnant women entered prenatal care during the first trimester (first three months) of pregnancy, compared to the national figure of 83.4%.[1,2]**
- **In Washington, the proportion of women entering prenatal care in the first trimester has significantly increased from the 1990 rate of 78.6%, mirroring a national pattern.[2,a]**
- **In 1999-2001, the women who were significantly more likely to begin prenatal care services in the first trimester were women over age 19, White or Asian women, Non-Hispanic women, non-Medicaid women, and women in urban core and urban fringe areas.[1,4,a]**
- **The Healthy People 2010 goal is to increase the percentage of all pregnant women who receive prenatal care in the first trimester to 90%.[3]**
- **The large proportion of birth certificates with missing data on prenatal care initiation continues to be a reporting issue. In 2001, month of onset of prenatal care was missing for 8.2% of live births.[1]**

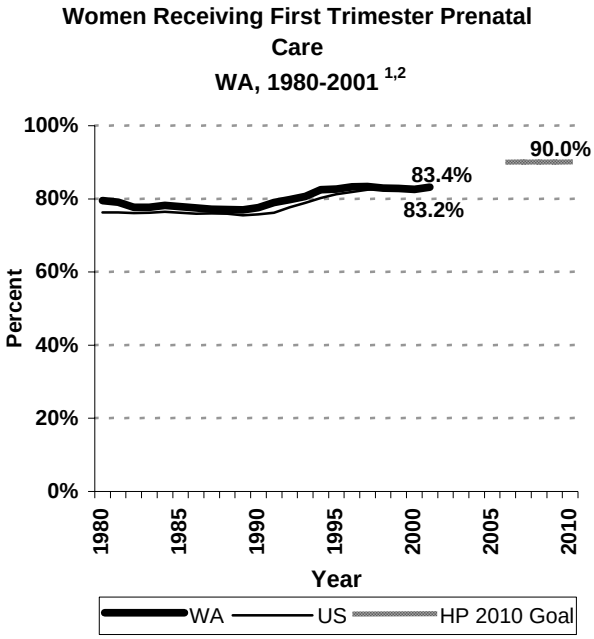
County

Women Receiving First Trimester Prenatal Care
By WA State and County
1999-2001 [1,a]

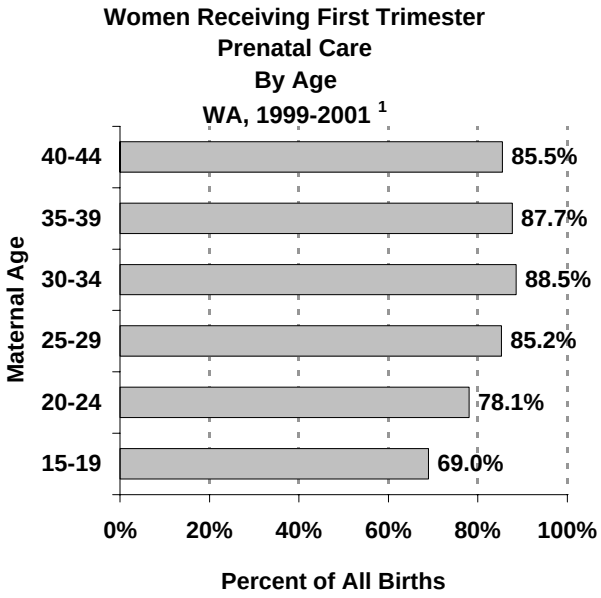


Prenatal Care (cont.)

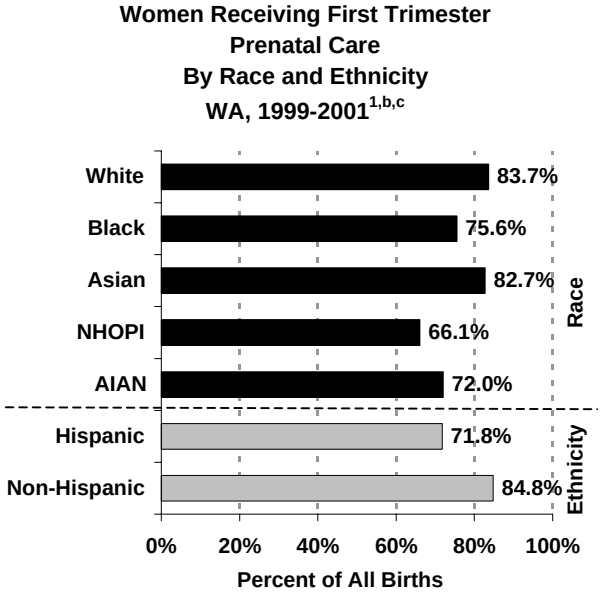
Time Trend



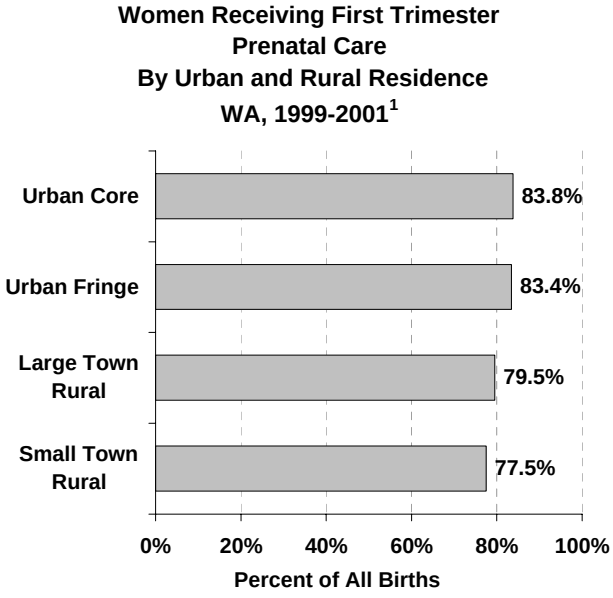
Age



Race and Ethnicity

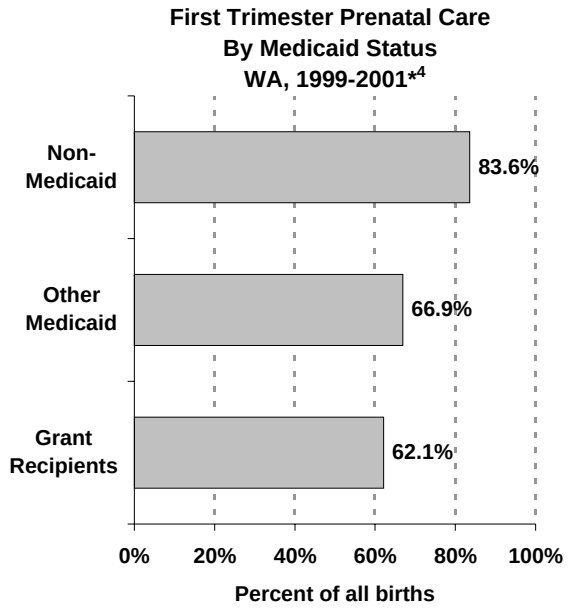


Rural and Urban Residence



Prenatal Care (cont.)

Medicaid Status



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Data Sources

[1] Washington State birth certificate data: Vital Statistics 2001, Washington State Department of Health, Center for Health Statistics, December 2002.

[2] Births: Final data for 2001. National Vital Statistics Report; Vol 52 No 2. Hyattsville, Maryland: National Center for Health Statistics. 2002.

[3] Department of Health and Human Services (US). Healthy People 2010: Understanding and Improving Health. 2nd edition. Washington, DC: US Government Printing Office; November 2000.

[4] Cawthon, L. Characteristics of Women Who Gave Birth in Washington State, Washington State Department of Social and Health Services, First Steps Database, 10/22/02.

Endnotes

[a] Significance was determined based on 95% Confidence Intervals.

[b] AIAN - American Indian Alaskan Native

[c] NHOPI - Native Hawaiian Other Pacific Islander

Preterm Delivery for Singleton Births

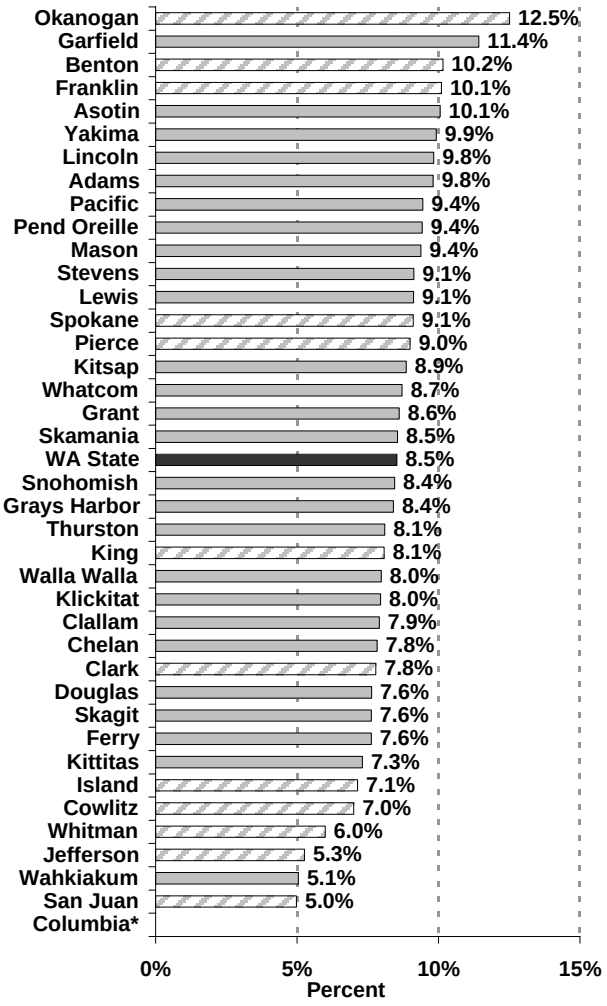
Definition: Preterm delivery is defined as a live birth before 37 completed weeks of gestation. This report is limited to data on singleton (one baby) births, unless otherwise noted.

Key Findings

- **Because trends in preterm delivery have been greatly influenced by the rise in multiple births, these data are limited to singleton (one baby) births, unless otherwise noted.**
- **Total preterm delivery in Washington increased from 8.4% in 1993 to 10.1% in 2001. During the same period, singleton preterm delivery increased from 7.6% to 8.9%. This increase is largely limited to births from 32-36 completed weeks of gestation. Nationally, total and singleton preterm delivery has also been increasing. In 2001, 11.9% of all births and 10.4% of singleton births in the US were preterm.[1,2]**
- **White women and non-Hispanic women in Washington had significantly lower preterm delivery rates compared to women of other races/ ethnicities.[1,a]**
- **Grant recipients were significantly more likely to have a preterm singleton delivery than other Medicaid or non-Medicaid women.[3]**
- **From 1999-2001, women ages 25 to 34 were significantly less likely to have a preterm delivery than both older and younger women.[1]**
- **The Healthy People 2010 objective is to reduce overall preterm birth to no more than 7.6 per 100 births.[4]**

County

Percent of Singleton Preterm Deliveries by County* WA, 1999-2001[1,a]

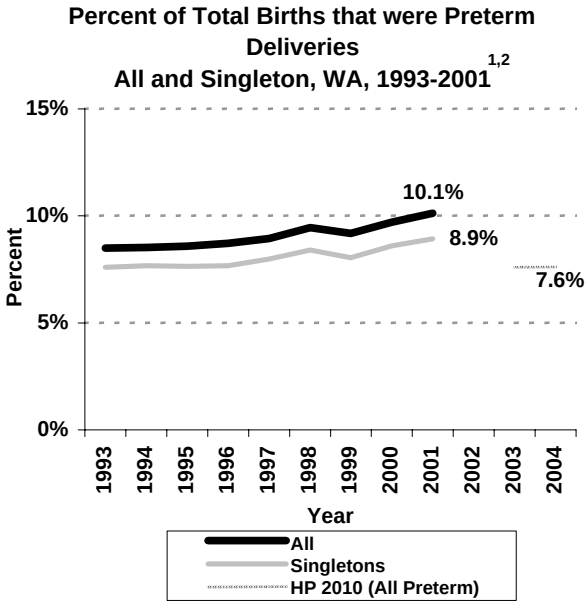


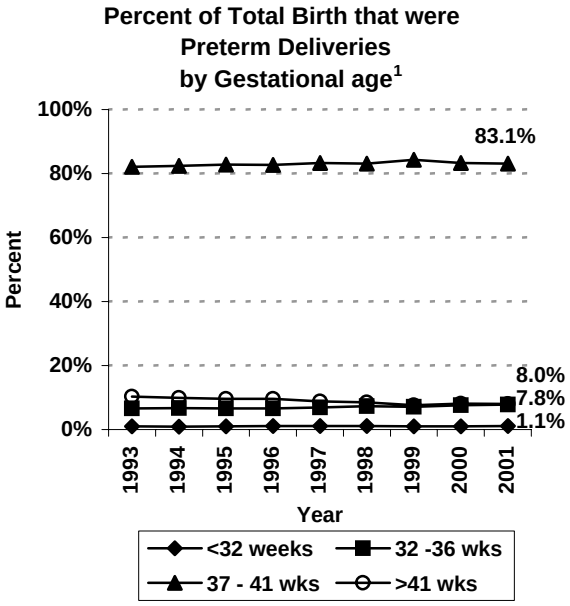
**County rate not calculated if less than 5 events.*

Significantly different from state rate

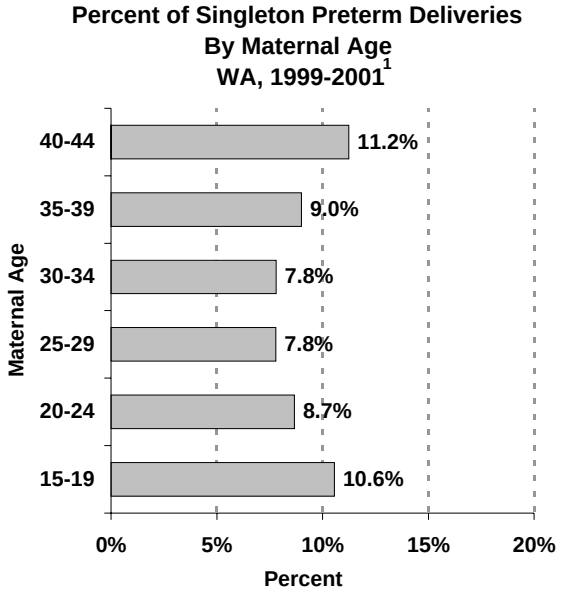
Preterm Delivery (cont.)

Time Trend

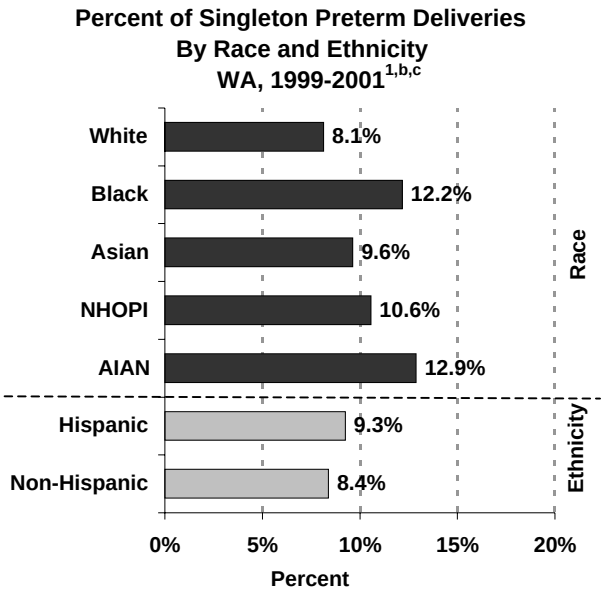




Age

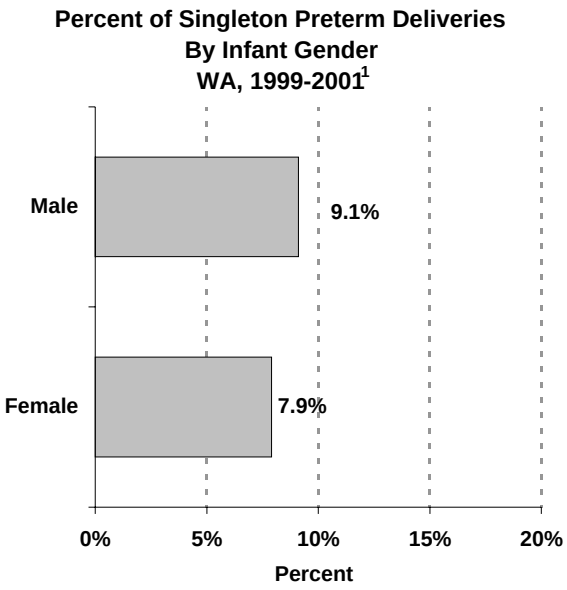


Race/Ethnicity

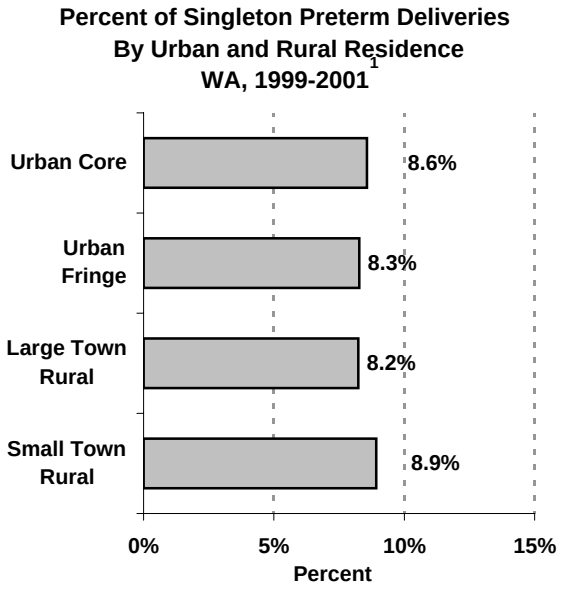


Preterm Delivery (cont.)

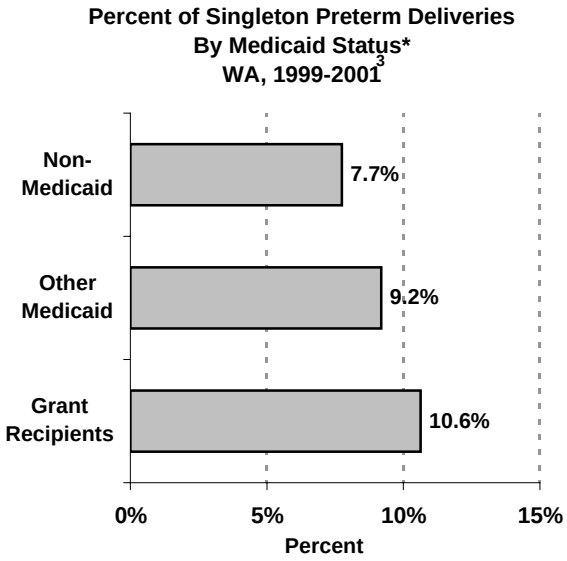
Infant Gender



Rural and Urban Residence



Medicaid Status



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[2] Births: Final data for 2001. National Vital Statistics Report; Vol 52 No 2. Hyattsville, Maryland: National Center for Health Statistics. 2002.

[3] Cawthon, L. Gestational Age by Mother's Medicaid Status, Washington State Department of Social and Health Services, First Steps Database, 9/17/03.

[4] Department of Health and Human Services (US). Healthy People 2010: Understanding and Improving Health. 2nd edition. Washington, DC: US Government Printing Office; November 2000.

Endnotes

[a] Significance was determined based on 95% Confidence Intervals.

[b] AIAN - American Indian Alaskan Native

[c] NHOPI - Native Hawaiian Other Pacific Islander

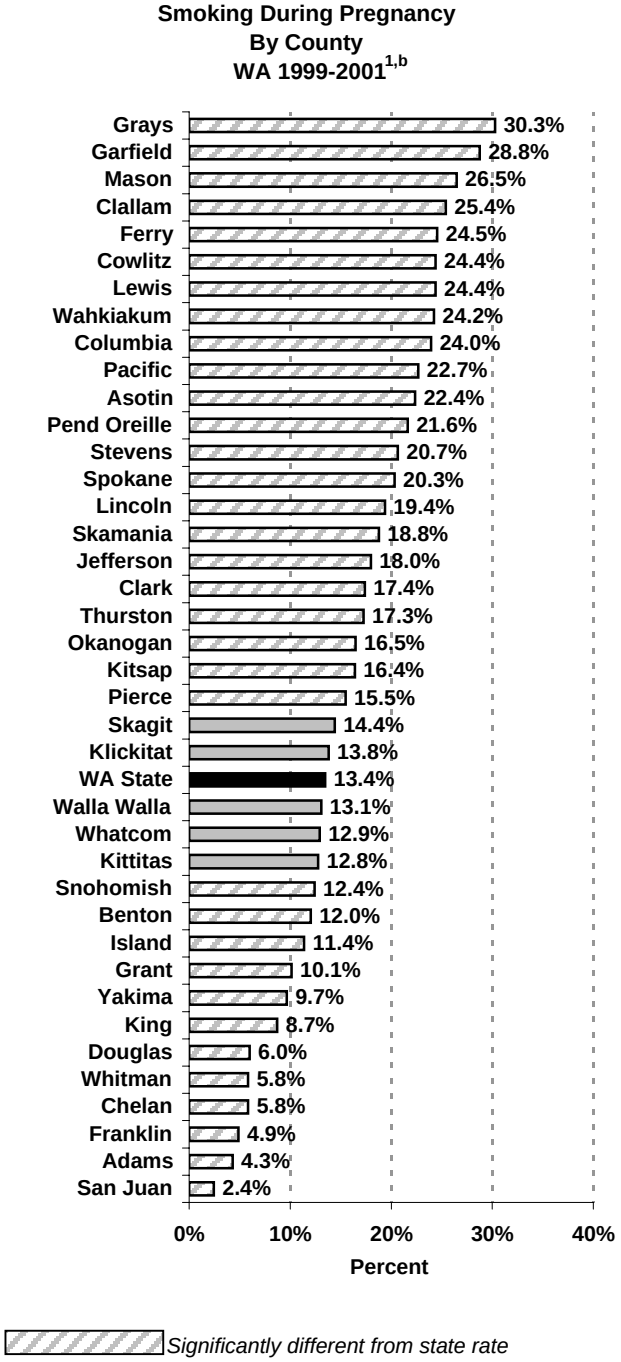
Smoking During Pregnancy

Definition: Smoking during pregnancy is defined as the mother smoking at any time during her pregnancy as reported on the Washington State Birth Certificate.[b]

Key Findings

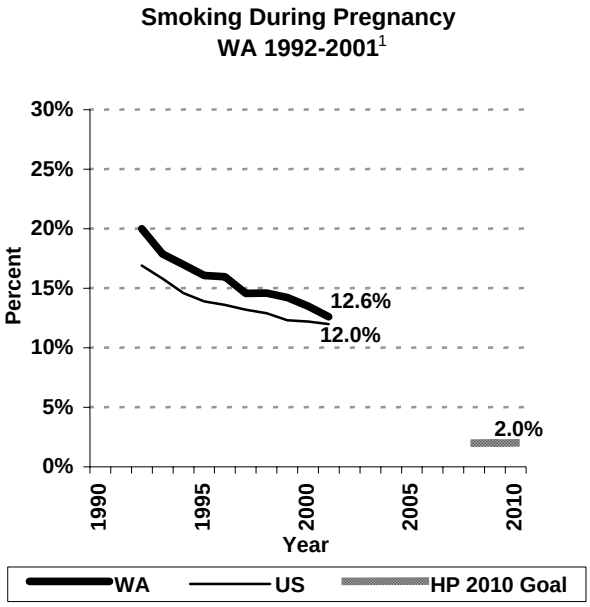
- **Tobacco smoking during pregnancy is the single most important preventable cause of low birth weight. Smoking is also associated with spontaneous abortion. Tobacco smoking among women with a live birth in Washington State decreased significantly from 20.1% in 1990 to 12.6% in 2001. Nationally in 2001, 12.0% of women with a live birth smoked during pregnancy.[1,2,3,c]**
- **American Indian/ Alaska Native women, Non-Hispanic women, women who were Grant Recipients, and women in small town rural areas were significantly more likely to report smoking during pregnancy. Rates of smoking during pregnancy decreased significantly among all races and ethnicities from 1990-2001.[1,5]**
- **Smoking during pregnancy was highest among women 15 -19 years of age and decreased with age until age 30. Smoking decreased significantly from 1990 to 2001 in all age groups except women ages 40-44 years.[1]**
- **Among PRAMS respondents in 2000, an estimated 24% reported smoking during the three months prior to pregnancy, 12% during the last three months of pregnancy and 17% postpartum. (Data not shown) [4,b]**
- **The Healthy People 2010 goal is for 99% of pregnant women to abstain from smoking during pregnancy and to increase smoking cessation during pregnancy to 30%.[2]**

County

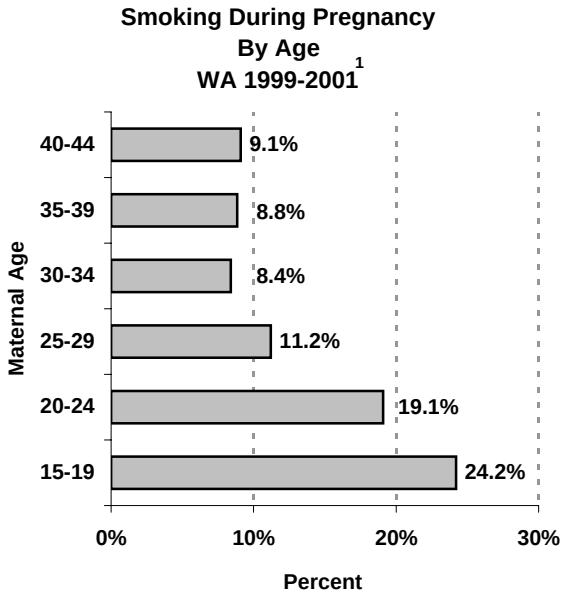


Smoking During Pregnancy (cont.)

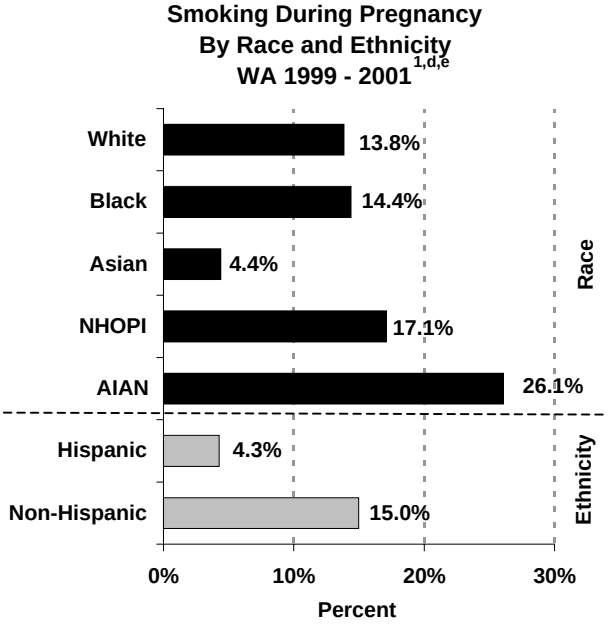
Trend



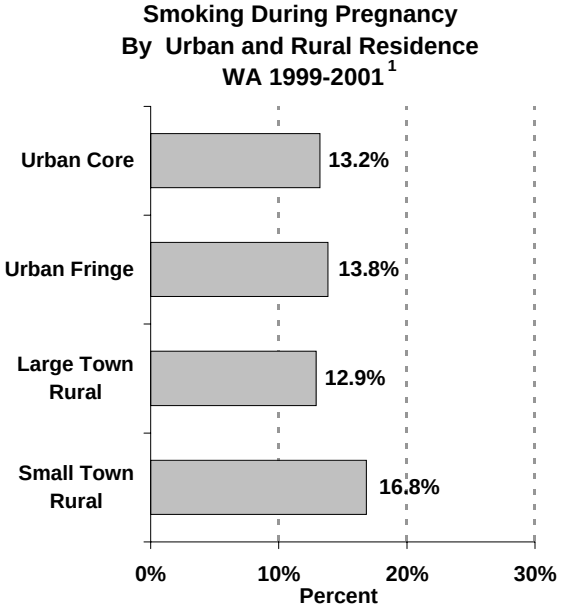
Age



Race and Ethnicity

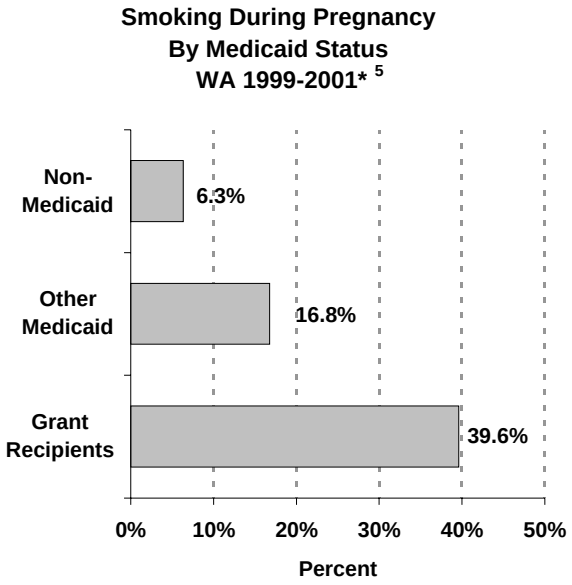


Rural and Urban Residence



Smoking During Pregnancy (cont.)

Medicaid Status



Medicaid women had either prenatal care or delivery paid by Medicaid. Medicaid women include those who are very low income and receive cash assistance (TANF) in addition to Medicaid **[Grant Recipients] and those who receive Medicaid with no cash assistance **[Other Medicaid]**.*

Data Sources

[1] Washington State birth certificate data: Vital Statistics 2001, Washington State Department of Health, Center for Health Statistics, December 2002.

[2] Department of Health and Human Services (US). Healthy People 2010: Understanding and Improving Health. 2nd edition. Washington, DC: US Government Printing Office; November 2000.

[3] Births: Final data for 2001. National Vital Statistics Report; Vol 52 No 2. Hyattsville, Maryland: National Center for Health Statistics. 2002.

[4] Washington Pregnancy Risk Assessment Monitoring System (PRAMS), 2000.

[5] Cawthon L. Smoking during pregnancy for women with Deliveries 1999-2001. Washington State Department of Social and Health Services, 7/30/2003.

Endnotes

[a] Significance was determined based on 95% Confidence Intervals.

[b] Data for the county-specific, age-specific, race and ethnicity, and rural-urban smoking rates are based on the percent of infants whose mothers smoked during pregnancy. Medicaid-specific rates and PRAMS data show the percent of pregnant women who reported smoking. Slight differences exist between these two measures.

[c] Some of this decline may be due to an increase in underreporting related to increased reticence to admit to tobacco use. We do not have data on changes in underreporting, however, research has indicated significant underreporting (up to 30%) of smoking during pregnancy (See Windsor R, Woodby L, Miller T. Effectiveness of AHCPR guidelines - patient education methods for pregnant smokers in Medicaid maternity care. Am J Obstet Gynecol 2000; 182:68-75).

[d] AIAN - American Indian Native Alaskan

[e] NHOPI - Native Hawaiian Other Pacific Islander

Substance Use in Adolescents

Definition: Current youth substance use refers to a youth (grades 6, 8 10 and 12) who has used alcohol, tobacco or other illicit substances on one or more of the past 30 days, as measured on the Healthy Youth Survey.

Key Findings

Tobacco Use

- **In 2002, about 22% of 12th graders, 15% of 10th graders, 9% of 8th graders, and 2% of 6th graders reported current cigarette smoking. Cigarette smoking in adolescents peaked in 1995-1998 (depending on the grade) and has been dropping in recent years.[1,2,4]**
- **The percent reporting regular tobacco use (tobacco use every day for the past 30 days) increases dramatically as students get older. Approximately 3% of 6th graders, 10% of 8th graders, 16% of 10th graders, and 25% of 12th graders report regular tobacco use.[2]**
- **The prevalence of smokeless tobacco use in 2002 was about 1% for 6th Grade, 3% for 8th Grade, 5% for 10th Grade and 8% for 12th graders. Smokeless tobacco use steadily declined among Washington youth throughout the mid to late-1990s but remained relatively constant from 2000 to 2002.[1,2]**

Alcohol Use

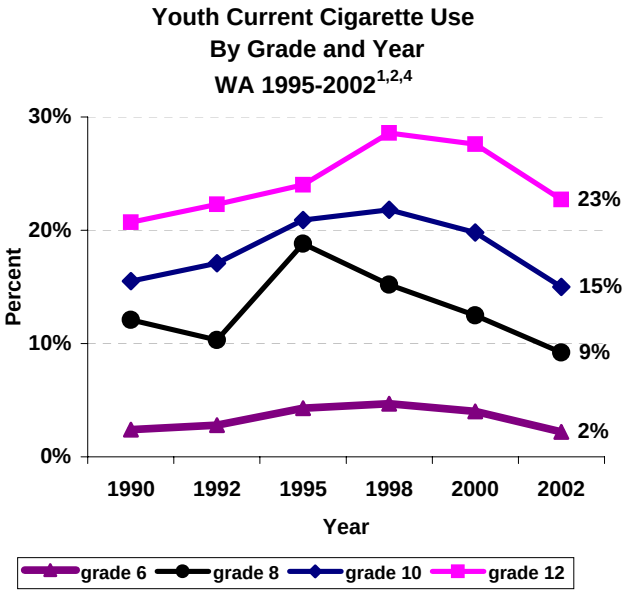
- **In 2002, an estimated 5% of 6th grade males used alcohol in the past 30 days compared to 2% of females, in 8th grade about 16% of males used alcohol compared to 19% of females, and in 12th grade about 45% of males used alcohol compared to 41% of females. Except for the 6th grade, there is not statistically significant difference in current alcohol use between male and female students.[2]**
- **In 2002, about 10% of 8th Grade students, 19% of 10th Grade students, and 27% of 12th Grade students reported binge drinking in the past two weeks. Binge drinking decreased among students in Grades 8 and 10 from 1998 to 2002.[1,2]**

Illicit Substance Use

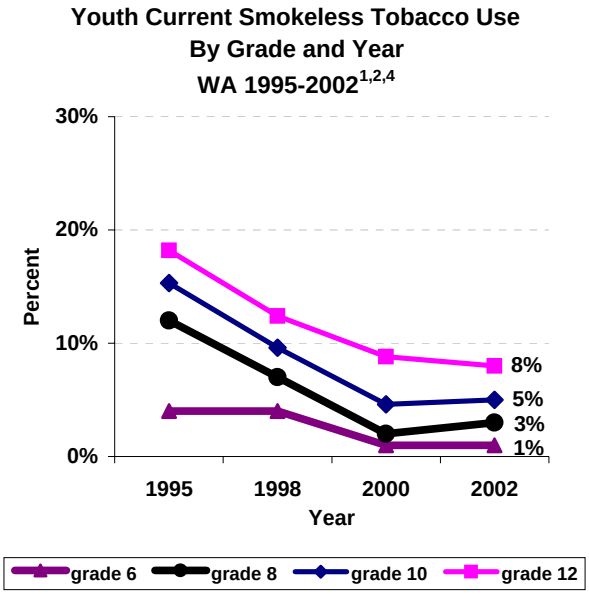
- **Students who report smoking tobacco are more likely to also report using other drugs. For instance, in 10th grade, about 52% of smokers reported using marijuana in the past 30 days, as compared to 4% of non-smokers.[2]**
- **Between 2% and 5% of students reported having used methamphetamine, cocaine, steroids or ecstasy in their lifetimes. For example, methamphetamine use in the past 30 days was reported by about 2% of Grade 8 students, 3% of Grade 10 students, and 2% of Grade 12 students.[2]**
- **Related Healthy People 2010 objectives are to reduce current cigarette use in students grades 9 - 12 to no more than 16%; reduce current smokeless tobacco use to no more than 1%; and to reduce binge drinking in 12th graders to no more than 11%.[3]**

Substance Use in Adolescents (cont.)

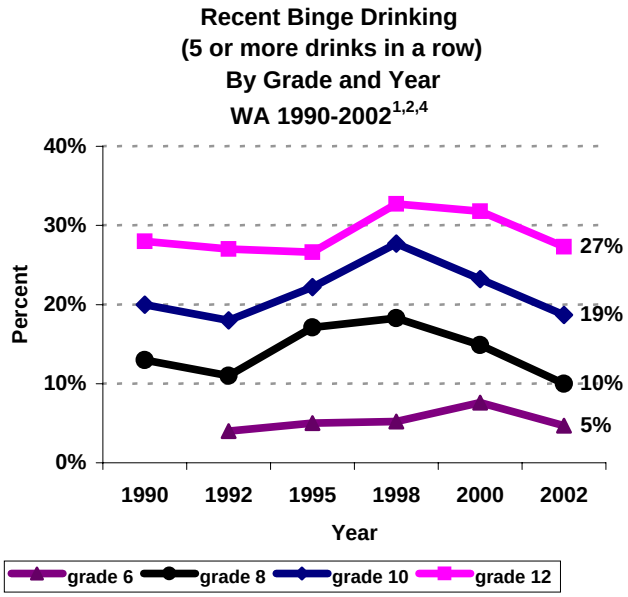
Cigarette Smoking



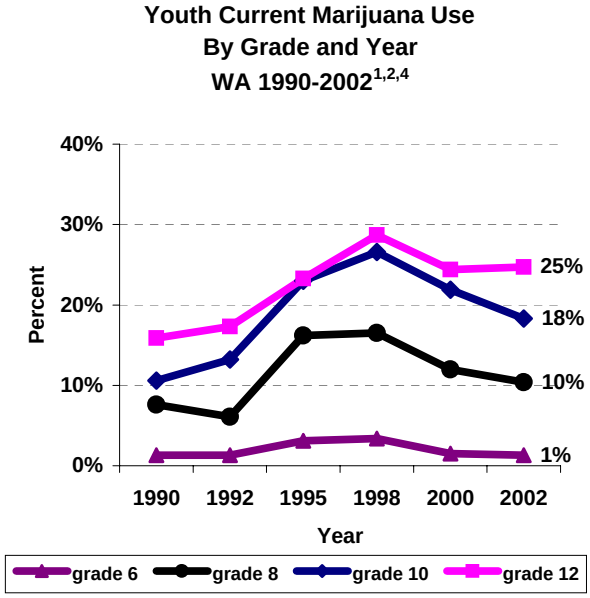
Smokeless Tobacco Use



Binge Drinking



Marijuana Use



Substance Use in Adolescents (cont.)

Data Sources

[1] Washington State Survey of Adolescent Health Behaviors 1992, 1995, 1998, 2000; Washington State Drug and Alcohol Survey, 1990

[2] Washington State Office of Superintendent of Public Instruction, Department of Health, Department of Social and Health Services, and Department of Community, Trade, and Economic Development and RMC Research Corporation. Washington State Healthy Youth Survey 2002: Analytic Report. In preparation.

[3] Department of Health and Human Services (US). Healthy People 2010: Understanding and Improving Health. 2nd edition. Washington, DC: US Government Printing Office; November 2000.

[4] Washington State Youth Risk Behavior Survey (YRBS), 1999

Unintended Pregnancy

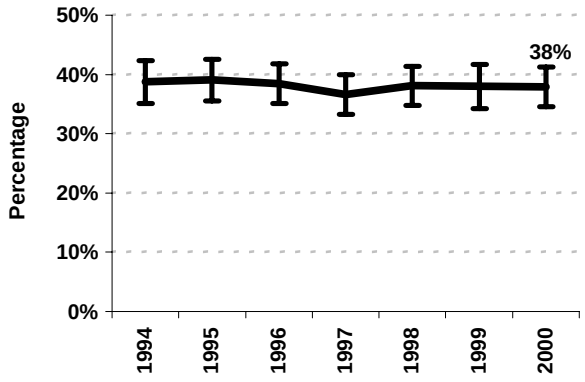
Definition: Unintended pregnancy refers to pregnancies that were mistimed (for example, mother wanted them to occur "later") or unwanted at the time of conception, Unintended pregnancy is measured as: (unintended live births + abortions) divided by total pregnancies (live births + abortions).

Key Findings

- **From 1998-2000, an estimated 53% of all pregnancies in Washington State were unintended. During that time, approximately 38% of live births were births from unintended pregnancies. The rate of unintended pregnancy resulting in live births has not changed significantly since 1994.[1,2]**
- **An estimated 71% of women less than 20 years of age and 28% of women ages 30-34 reported births from unintended pregnancies.[2]**
- **Among live births, Black (about 57%) and American Indian /Alaska Native women (about 53%) were significantly more likely to report their birth was from an unintended pregnancy compared to Asian (about 38%) and White women (about 36%).[2]**
- **Grant recipients were significantly more likely to report their birth was from an unintended pregnancy (about 71%) than other women on Medicaid (51%) or women not receiving Medicaid (27%).[2]**
- **The Healthy People 2010 objective is to increase to 70% pregnancies that are intended.[3]**

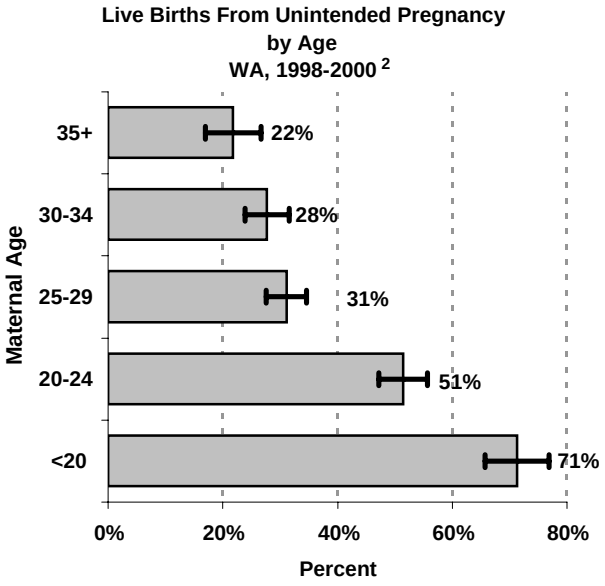
Time Trend

Live Births From Unintended Pregnancies WA, 1994-2000 [2]

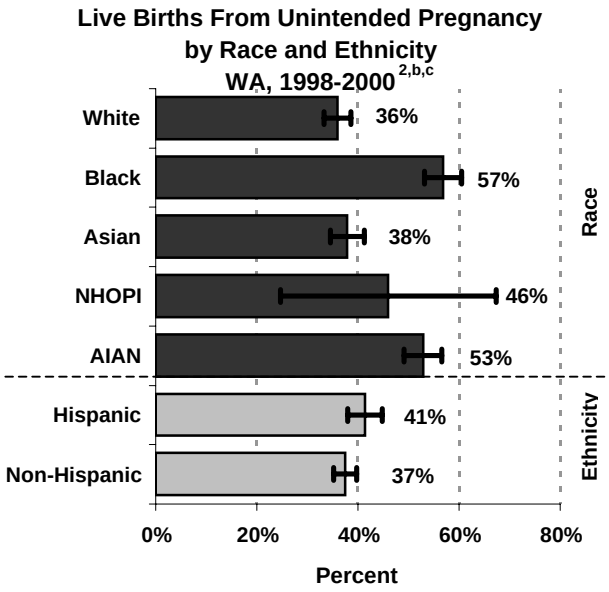


Unintended Pregnancy (cont.)

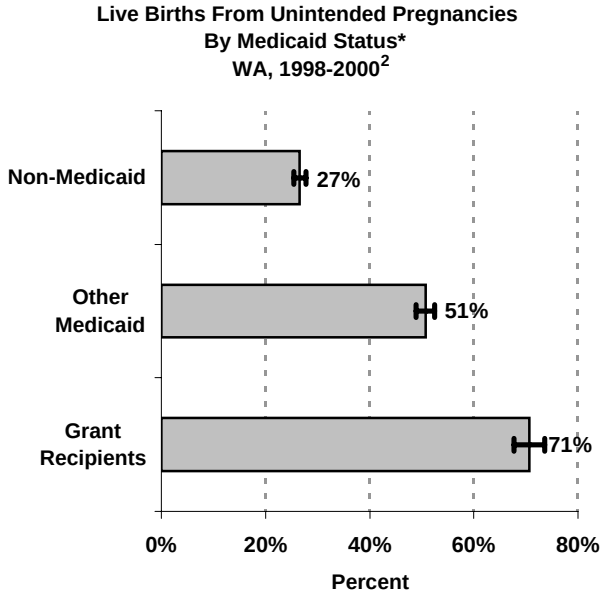
Age



Race and Ethnicity



Medicaid Status*,[a]



Data Sources

[1] Washington State Pregnancy and Induced Abortion Statistics 2000, CHS March 2002.

[2] Pregnancy Risk Assessment Monitoring System (PRAMS), Washington State Department of Health, 1998-2000.

[3] Department of Health and Human Services (US). Healthy People 2010: Understanding and Improving Health. 2nd edition. Washington, DC: US Government Printing Office; November 2000.

Endnotes

[a] The source for the Medicaid designations used in PRAMS is the Washington State Department of Social and Health Services, First Steps Database.

[b] AIAN - American Indian Alaskan Native

[c] NHOPI - Native Hawaiian Other Pacific Islander

Medicaid women had either prenatal care or delivery paid by Medicaid. Medicaid women include those who are very low income and receive cash assistance (TANF) in addition to Medicaid **[Grant Recipients] and those who receive Medicaid with no cash assistance **[Other Medicaid]**.*

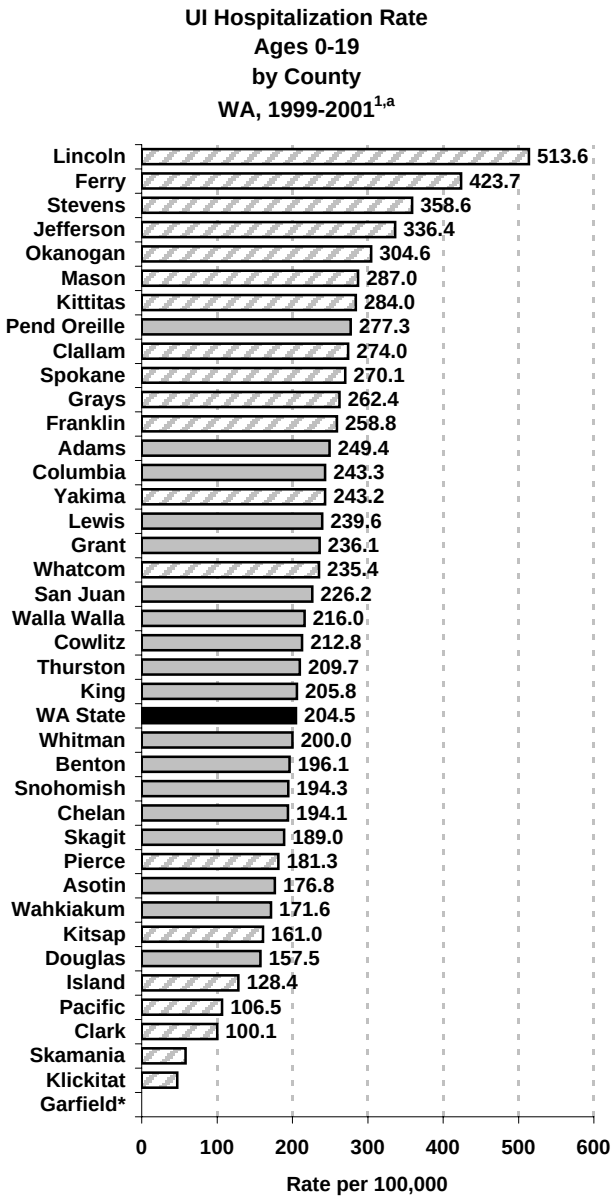
Unintentional Injury Hospitalizations

Definition: Unintentional injury hospitalizations are nonfatal hospitalizations due to unintentional injuries (ICD-9 codes E800-E869 and E880-E929). They include adverse effects, which are injuries related to therapeutic use of drugs and adverse effects of medical and surgical care. Unintentional injury hospitalizations include the primary diagnosis only. The data source is the Washington State Comprehensive Hospital Abstract Reporting System, (CHARS). Patients hospitalized more than once with the same diagnosis will be counted as separate incidents.

Key Findings

- **There were 3,348 nonfatal unintentional injury (UI) hospitalizations for Washington children ages 0-19 in 2001, for a rate of 197.6 per 100,000. This represents a 45% decrease from the 1990 rate of 355 per 100,000[1,2]**
- **The highest UI hospitalization rates for Washington children were in infants less than 1 year old and children ages 15-19. Males ages 0-19 had significantly higher UI hospitalization rates than females.[1,a]**
- **Washington children in small town rural areas had significantly higher unintentional injury hospitalization rates than children in urban areas.[1]**
- **While the leading causes of unintentional injury hospitalization vary by age, overall the three most common causes for UI hospitalizations for Washington children were falls, motor vehicle (occupant), and struck by or against (which includes injuries caused by being accidentally struck by an object or person).[3]**

County

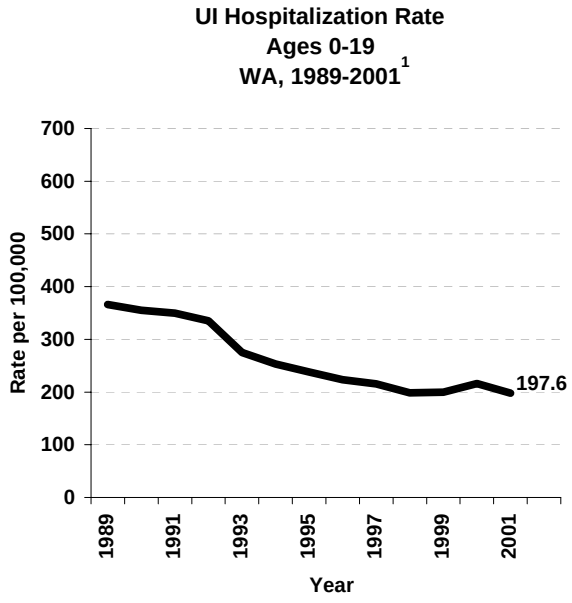


**County rate not calculated if less than 5 events.*

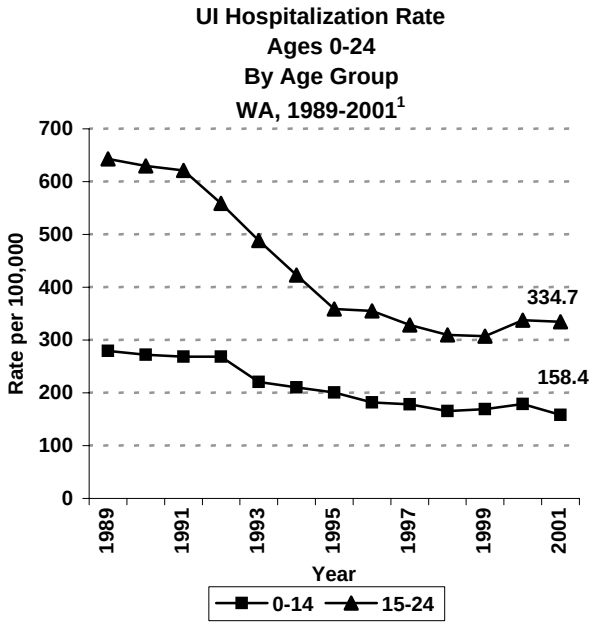
Significantly different from state rate

Unintentional Injury - Hospitalizations (cont.)

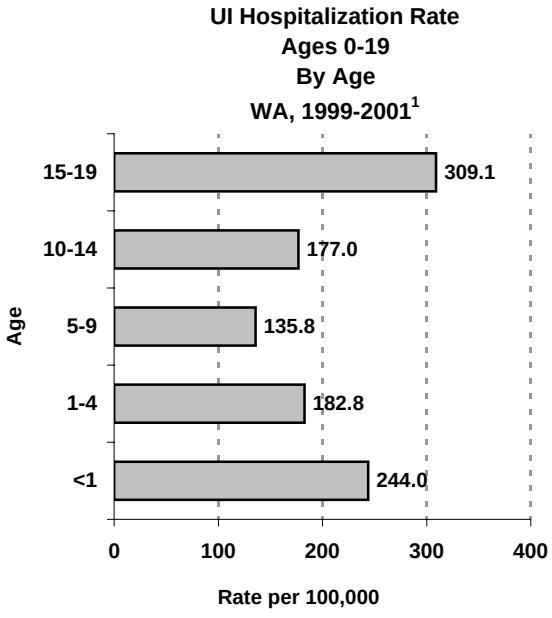
Time Trend



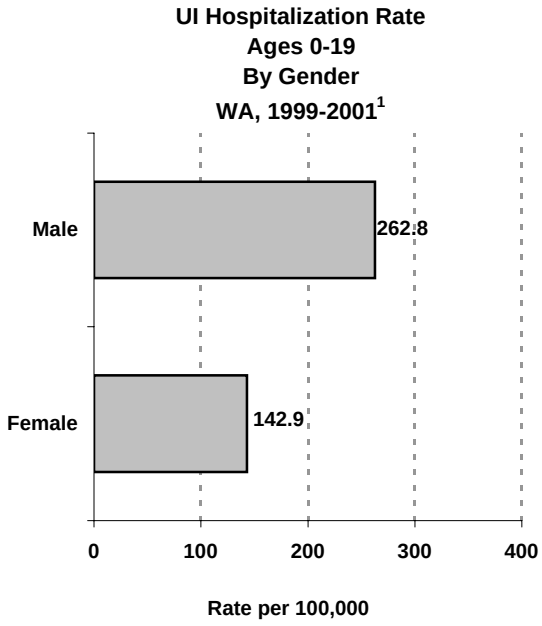
Block Grant Measure:
Unintentional Injury 0 to 24 year olds



Age

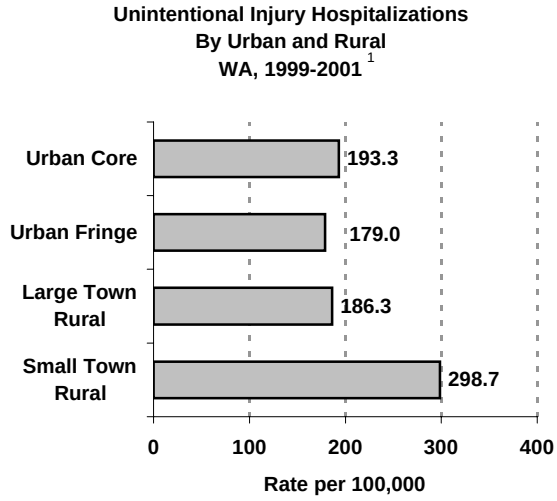


Gender

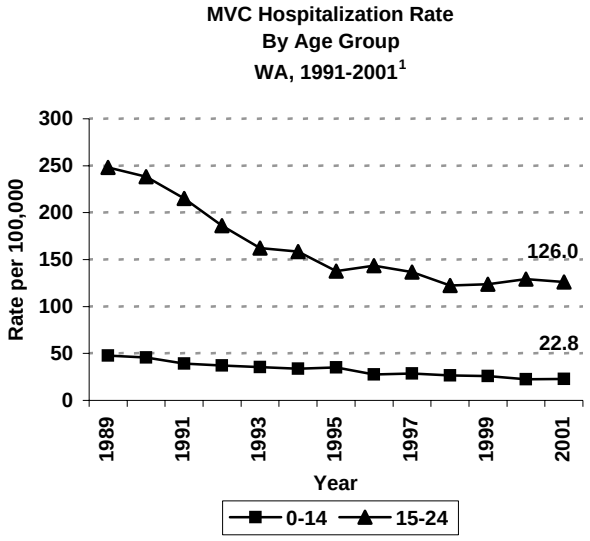


Unintentional Injury - Hospitalizations (cont.)

Rural and Urban Residence



Motor Vehicle Crashes (MVC)



Leading Causes of Unintentional Injury Hospitalizations, 1997-2001[3]

WA Children Ages 0-19, By Age Group

Rank	<1	1 - 4	5 - 9	10 - 14	15 - 19
1st	Falls	Falls	Falls	Falls	Motor Vehicle (occupant)
2nd	Fire/ Hot Object or Substance	Poisoning	Bicycle (rider)	Struck by or against	Falls
3rd	Suffocation	Fire/ Hot Object or Substance	Motor Vehicle (occupant)	Bicycle (rider)	Struck by or against an object or person

Data Sources

[1] Comprehensive Hospital Abstract Reporting System (CHARS), Washington State Department of Health, 1987-2001.

[2] Analysis Software: Public Health - Seattle & King County, Epidemiology, Planning & Evaluation, Software for Public Health Assessment (VistaPHw), 1991-.

[3] Injury Prevention and Safety Program, Washington State Department of Health: http://www.doh.wa.gov/cfh/Injury/Tables_update.htm .

Endnotes

[a] Significance was determined based on 95% Confidence Intervals.

Unintentional Injury Mortality

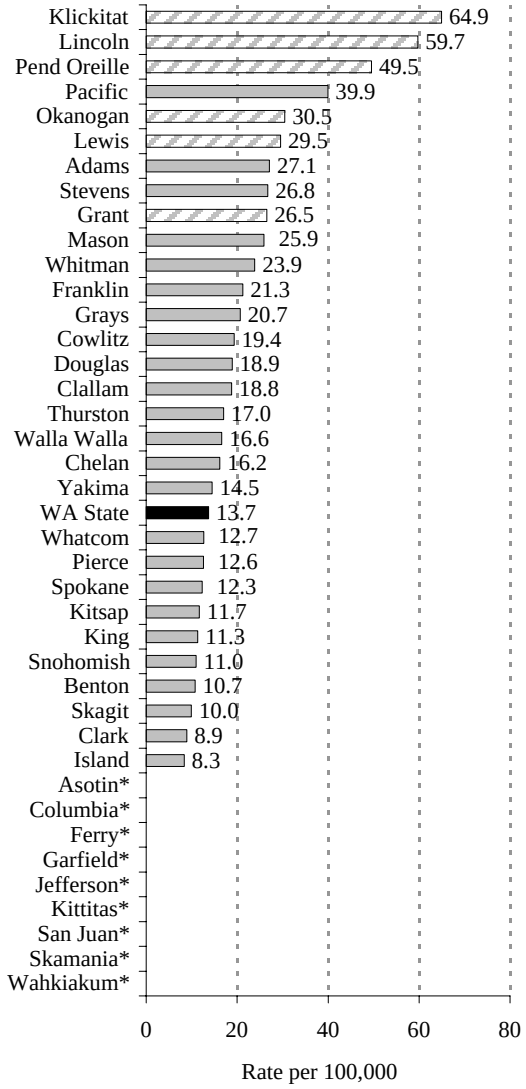
Definition: Unintentional Injury deaths include those deaths due to accidental causes.[a]

Key Findings

- **In 2001, there were 227 deaths due to unintentional injury (UI) for Washington state residents ages 0-19. The UI death rate for Washington children ages 0-19 decreased from 36.1 per 100,000 in 1980 to 13.4 per 100,000 in 2001. Deaths due to motor vehicle crashes, which are the leading cause of unintentional injury deaths in children, decreased from 20.4 per 100,000 Washington children ages 0-19 in 1980 to 7.5 per 100,000 in 2001.[1,2]**
- **Among Washington children ages 0-19, unintentional injury death rates are highest in males, American Indian/ Alaska Natives, infants and adolescents ages 15-19 years.[1]**
- **While the leading causes of unintentional injury deaths vary by age of the child, the leading causes for all Washington residents ages 0-19 are motor vehicle traffic, drowning, and suffocation.[3]**
- **Washington's local Child Death Review (CDR) teams reviewed 357 unintentional injury deaths of children ages 0-17 from 1999-2001 and concluded that 287 (80%) of these deaths were preventable.[4]**
- **The Healthy People 2010 goal is to reduce the UI death rate for the whole population to no more than 17.5 per 100,000 population and motor vehicle crashes to no more than 9.2 deaths per 100,000 population.[5]**

County

Unintentional Injury Death Rate, Age 0-19 By County WA, 1999-2001 *1,b

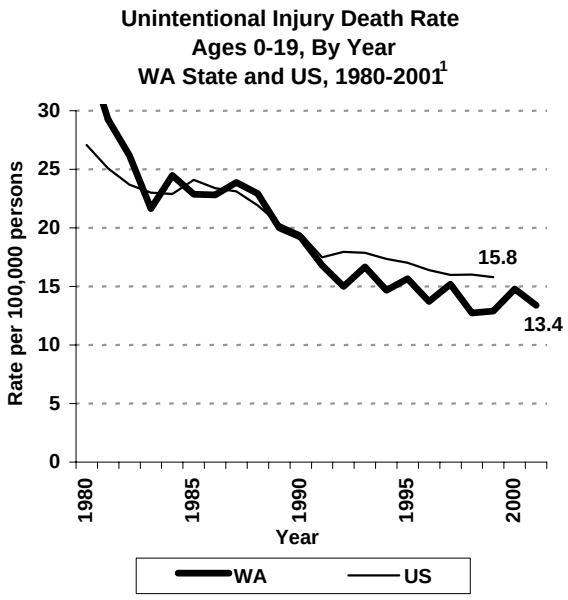


**County rates not calculated if less than 5 events.*

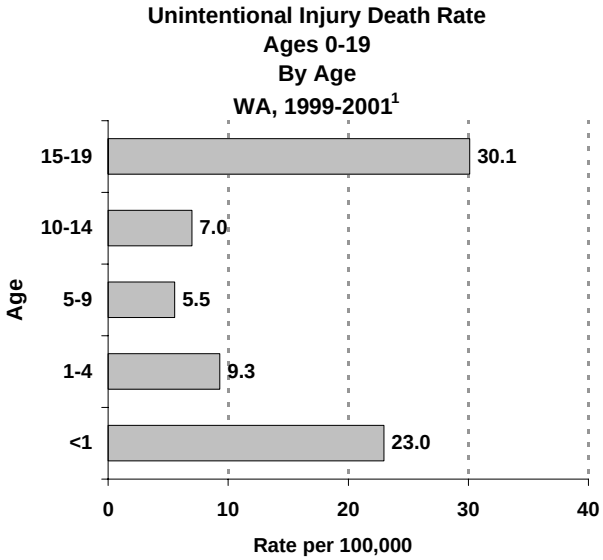
Significantly different from state rate

Unintentional Injury Mortality (cont.)

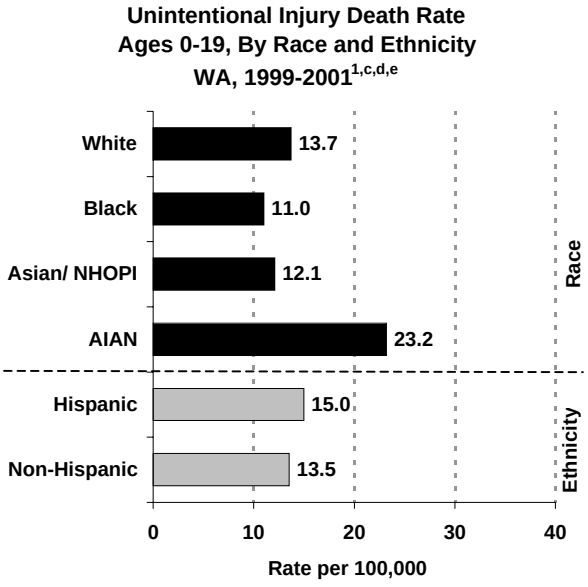
Time Trend



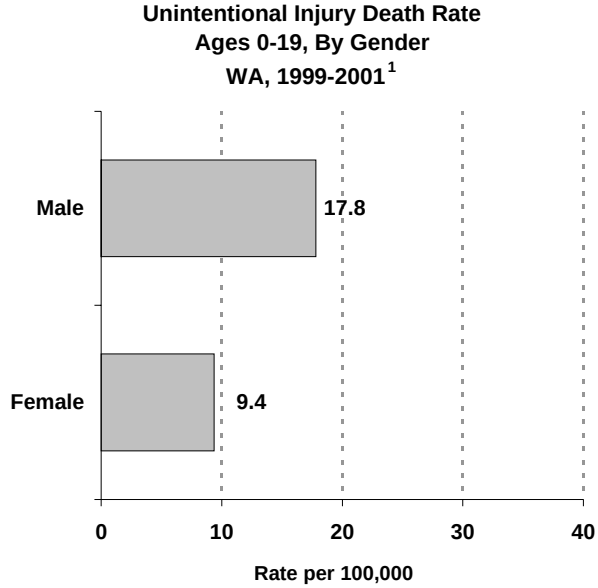
Age



Race and Ethnicity



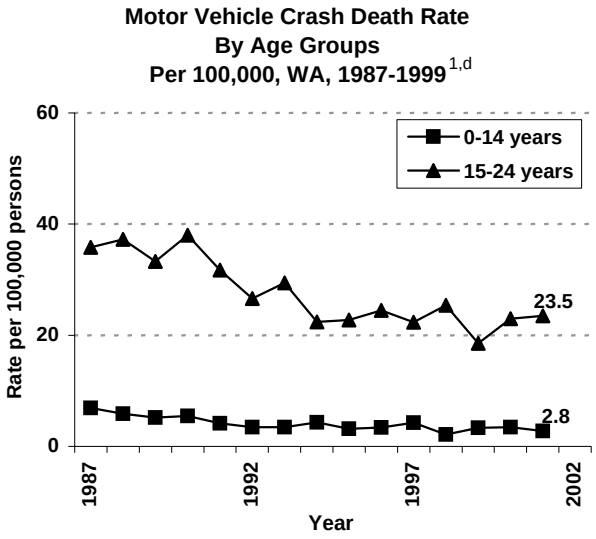
Gender

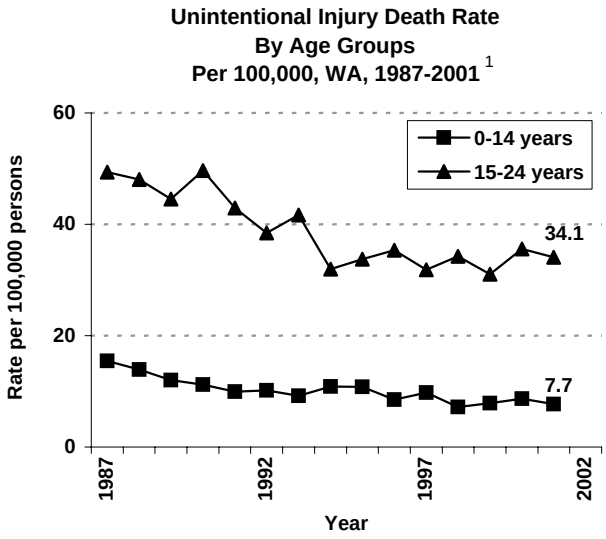


Unintentional Injury Mortality (cont.)

Block Grant Measure:
Motor Vehicle Crashes

Time Trend by Age





Leading Causes of Unintentional Injury Deaths, 1999-2001[3]

WA Children Ages 0-19, by Age Group

Rank	<1	1 - 4	5 - 9	10 - 14	15 - 19
1st	Suffocation (N=31)	Motor Vehicle Traffic (N=35)	Motor Vehicle Traffic (N=37)	Motor Vehicle Traffic (N=39)	Motor Vehicle (N=269)
2nd	Motor Vehicle Traffic (N=9)	Drowning (N=18)	Drowning (N=11)	Drowning (N=17)	Drowning (N=44)
3rd	Drowning (N=4)	Suffocation (N=13)	Suffocation (N=5)	Suffocation (N=7)	Poisoning (N=23)
4th	Struck By or Against (N=4)	Fire (N=10)	Struck by or Against (N=4)	Fire (N=5)	Fall/Jump/Push (N=8)

Data Sources

[1] Washington State death certificate data: Vital Statistics 2001, Washington State Department of Health, Center for Health Statistics, December 2002.

[2] Analysis Software: Public Health - Seattle & King County, Epidemiology, Planning & Evaluation, Software for Public Health Assessment (VistaPHw), 1991-.

[3] Injury Prevention and Safety Program, Washington State Department of Health: http://www.doh.wa.gov/cfh/Injury/Tables_update.htm .

[4] Data from the Washington State Child Death Review Database, MCH Assessment Section, Washington State Department of Health,1999-2001.

[5] Healthy People 2010: Understanding and Improving Health, US Department of Health and Human Services, Washington DC US Government Printing Office, 2000.

Endnotes

[a] The ICD-10 codes for unintentional injury deaths used from 1999 to the present include V01-X59 and Y85-Y86. The ICD-9 codes used prior to 1999 include E800-E869 and E880-E929. Comparability ratio (used to enable comparison

[b] Significance was determined based on 95% Confidence Intervals.

[c] Population denominators for non-Hispanics are estimated by subtracting the number of Hispanics from the total population and may include unknowns.

[d] AIAN - American Indian Alaskan Native

[e] NHOPI - Native Hawaiian Other Pacific Islander

Data Sources:

Behavioral Risk Factor Surveillance System (BRFSS): This is a national telephone survey of adults ages 18 and older that monitors modifiable risk factors for chronic diseases and other leading causes of death. For the Washington State BRFSS website, please go to *http://www.doh.wa.gov/EHSPHL/CHS/CHS-Data/brfss/brfss_homepage.htm.* For CDC BRFSS information, please go to *CDCs Behavioral Risk Factor Surveillance System* web site (or http://www.cdc.gov/brfss/).

Birth Certificates: For more information about what data are collected on the Washington State Birth Certificates, please go to *Washington State Department of Health - Birth Certificates* web site (or http://www.doh.wa.gov/EHSPHL/CHS/CHS-Data/birth/bir_main.htm).

Census: Current Washington State census data are available from the Washington State Office of Financial Management at the *OFM Population. Economy and Research* (or http://www.ofm.wa.gov/sps/index.htm) web site and U.S. Census Bureau at *Census Bureau Home Page* (or http://www.census.gov/).

Child Death Review (CDR): Washington's Child Death Review data come from reviews submitted to a state database by local CDR teams operating across the state. Child Death Review is a process by which local communities establish a multi-disciplinary team representing public health, medical providers, law enforcement, school counselors and other agencies and professions. Each team identifies circumstances leading to such deaths; collect and report accurate, uniform information; improve interagency communication; and develop strategies to improve child health and safety. From 1998 through June 2003, 29 community-based CDR teams covered the entire state of Washington through contracts with 34 local health jurisdictions. Each contractor convened a multidisciplinary team (5-20 members) that reviewed unexpected deaths of children age birth to 18 years residing in that jurisdiction using a standardized data collection tool and submitted these reviews to the Washington State Department of Health. (See: <http://www.doh.wa.gov/cfh/mch/cahcp/cdr.htm>)

CSHCN Survey: This survey explores the extent to which children with special health care needs (CSHCN) have medical homes, adequate health insurance, and access to needed services. Other topics include care coordination and satisfaction with care. It is administered by the National Center for Health Statistics as a module within the **State and Local Area Integrated Telephone Survey** *(SLAITS survey methodology. For more information visit the SLAITS website at N C H S - S L A ITS **home page*** (or http://www.cdc.gov/nchs/slaits.htm).

Current Population Survey (CPS): This is a monthly sample household survey of the non-institutional civilian population in the United States. Most of the information collected is on unemployment and the labor force, though also is used for supplemental studies such as tobacco use and marital and birth history. For the CPS Website, please go to *Current Population Reports* (or http://www.census.gov/main/www/cprs.html).

Appendix A: Technical Notes

Death Certificates: For more information about what data are collected on the Washington State Death Certificates, please visit the *Washington State Department of Health - Death Certificates* web page (or http://www.doh.wa.gov/EHSPHL/CHS/CHS-Data/death/deatmain.htm). For more information of the International Classification of Disease (ICD) 10 codes used in the Death Certificates, please visit the *Death Certificates. Technical Notes* web page (or http://www.doh.wa.gov/ehsphl/chs/chs-data/TechNote/tech_not.pdf).

Fetal Death Certificates: For more information about fetal death certificates, please visit the *Washington State Department Of Health - Fetal Death* webpage (or http://www.doh.wa.gov/ehsphl/chs/chs-data/fetdeath/fd_main.htm).

Healthy People 2010: Healthy People 2010 is a set of national health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce these threats. Source for national health objectives for Year 2010, found at http://www.healthypeople.gov/document/ .

Healthy Youth Survey 2002: The Healthy Youth Survey (HYS) is a collaborative effort of the Office of the Superintendent of Public Instruction, the Department of Health, the Department of Social and Health Service's Division of Alcohol and Substance Abuse, and the Office of Community Development. The Healthy Youth Survey provides important information about adolescents in Washington. County prevention coordinators, community mobilization coalitions, community public health and safety networks, and others use this information to guide policy and programs that serve youth. The information from the Healthy Youth Survey can be used to identify trends in the patterns of behavior over time. The state-level data can be used to compare Washington to other states that do similar surveys and to the nation. In the Fall of 2002, students in grades 6, 8, 10 and 12 answered questions about safety and violence, physical activity and diet, alcohol, tobacco and other drug use, and related risk and protective factors. The Healthy Youth Survey will next be administered in the Fall of 2004. State level data are available at: http://www3.doh.wa.gov/HYS/ .

International Classification of Disease (ICD) Codes: ICD codes are used for the CHARS dataset and death certificate data. Starting in 1999, mortality data switched from using ICD-9 to using ICD-10 codes. In order to view trends in Death Certificate data, comparability ratios (available from the National Center for Health Statistics) are used. Morbidity data (CHARS datasets) currently use ICD-9 codes.

National Immunization Survey: This phone survey of adults with children ages 19 to 35 months is conducted by the National Center for Health Statistics. For more information, please visit the *NCHS - National Immunization Survey* website **(or** http://www.cdc.gov/nis).

National Vital Statistics Reports: Source for national birth and death data. See data at: http://www.cdc.gov/nchs/products/pubs/pubd/nvsr/nvsr.htm .

The Pregnancy Risk Assessment Monitoring System (PRAMS): The Pregnancy Risk Assessment Monitoring System survey is an ongoing, population-based surveillance system sponsored by the Centers for Disease Control and Prevention (CDC) and the Office of Maternal and Child Health. PRAMS is designed to generate state-specific data

for assessing health status and health care before, during, and after a pregnancy and is administered 2-5 months postpartum. The information can be used for health and social services planning and policy development. DOH's PRAMS webpage is *Pregnancy Risk Assessment Monitoring system* (or http://www.doh.wa.gov/cfh/PRAMS/default.htm), and the CDC's PRAMS webpage is the *Pregnancy Risk Assessment Monitoring System* (or http://www.cdc.gov/reproductivehealth/srv_prams.htm).

VISTA: Vista is a menu-driven software package that facilitates analysis of population-based health data. For more information on VISTA software and its uses, please visit the Vista webpage (http://www.doh.wa.gov/OS/Vista/HOMEPAGE.HTM).

Washington State Smile Survey: The Washington State Smile Survey included a sample of infants and toddlers and a random sample of public elementary school 2nd and 3rd graders. The portion of the survey that addressed 1-2 year olds was a collaborative effort with the Statewide Lead Poisoning Prevalence Survey, with over-sampling for Hispanic children and children of farm workers. The sampling frame also included a convenience sample of 6 of the 10 Early Start programs along with a Head Start program in the same community. Included in the questionnaire was a short demographic profile of the family to enhance understanding regarding access to dental care, economic status (eligibility for free/reduced meal program), and language spoken at home. Each child participating in the survey received an oral screening exam to determine the child's caries experience, treatment need and urgency, dental sealants needs, and a saliva sample for measuring the level of *Streptococcus mutans.* The year 2000 Survey gathered data on more than 3,500 children, 2,699 of which were in the elementary school sample (40% response rate). Please click here for a copy of the *Smile Survey 2000 Report*.

Washington State Comprehensive Hospital Abstract Reporting System (CHARS): This is a record of International Classification of Disease (ICD) diagnosis codes upon hospital discharge. ICD-9 codes are currently used for CHARS data, though there will be a shift to using ICD-1 0 codes in the future. For more information, visit the DOH website at: http://www.doh.wa.gov/EHSPHL/hospdata/ .

Washington State Population Survey: The Washington State Population Survey is a sample household survey of Washington State's population, completed by the Washington State Office of Financial Management, and used to create Intra-census Population Estimates for Washington State. For more information, visit the *OFM Population. Economy and Research* webpage (or http://www.ofm.wa.gov/sps/index.htm).

Washington State Survey of Adolescent Health Behaviors 2000: This survey was conducted jointly by the Department of Social and Health Services, the Office of the Superintendent of Public Instruction, the Department of Community Trade and Economic Development, and the Department of Health tobacco program. The survey was administered during class time to public school students in grades 6, 8, 10 and 12. The sample was stratified by geographic region and school size, and within these cells, where possible, a school was selected from each of three community types: urban, suburban, and rural. All students in selected schools were invited to participate. The survey asked a variety of questions about alcohol, tobacco, and drug use and risk and protective factors. Data were analyzed using Software for the Statistical Analysis of Correlated Data (SUDAAN) because of the complex sampling design (clustered by schools).

Appendix A: Technical Notes

Washington State Vital Statistics System: The vital statistics system monitors births, deaths, marriages, divorces, and fetal deaths for Washington State. Please visit the *Washington State Department of Health - Center for Health Statistics* website (or http://www.doh.wa.gov/EHSPHL/CHS/CHS-Data/main.htm).

Washington State Youth Risk Behavior Survey (YRBS), 1999: The Washington State YRBS was based on the Centers for Disease Control and Prevention (CDC) survey instrument. The YRBS is intended to monitor adolescent health-risk behaviors that contribute to morbidity, mortality, and social problems among youth and adults in the United States. The Washington YRBS used a two-stage sampling design: schools were chosen using a probability-proportionate-to-size sampling of all public schools serving children grades 9-12 (which ensured that smaller schools had some chance of selection). Once schools were chosen, a random sample of classrooms was selected within participating schools. A sample of 4,022 adolescents in Washington State public schools participated in the YRBS 1999 survey. Alternative schools serving high-risk youth in the public school system were included. Based on four comparison items that were also administered to a census of eleventh graders in the state during achievement testing, results seemed to be representative of adolescents in public schools despite the low school participation rate (45%). For a full report, please go to *Washington State Youth Risk Behavior Survey:* 1999. The CDC's webpage is available at *Youth Risk Behavior Surveillance system (YRBSS)* (or http://www.cdc.gov/nccdphp/dash/yrbs/index.htm).

Other CDC-Based Surveys: To learn about other National Surveys and Data Collection Systems produced by the National Center for Health Statistics, please visit the *NCHS - Surveys and Data Collection Systems* webpage (or http://www.cdc.gov/nchs/express.htm).

Statistical Terms

Rates: For more information on interpreting rates, please go to the *Washington State Department of Health - Guidelines for developing rates for public health assessment* (or http://www.doh.wa.gov/Data/guidelines/Rateguide.htm) website.

Confidence Intervals: A confidence interval is a range of values that is normally used to describe the uncertainty around a point estimate of a quantity, for example, a mortality rate. Therefore confidence intervals are a measure of the variability in the data. Generally speaking, confidence intervals describe how much different the point estimate could have been if the underlying conditions stayed the same, but chance had led to a different set of data. Confidence intervals are calculated with a stated probability (say 95%), and we say that there is a 95% chance that the confidence interval covers the true value. Most 95% confidence intervals for the same reason that most statistical tests are done at the 0.05 level- in other words, only because it's conventional. It is completely arbitrary that we consider a result that would happen only 5 out of 100 times by chance as being statistically significant, while we consider one happening 6 out of 100 times as not being statistically significant. It is good to remember that the true population value is a constant, even though its value is unknown, but a confidence interval is a random quantity whose value depends on the random sample or data from which it is calculated.

Therefore we describe a 95% (say) confidence interval as having a 95% probability of covering the true value, rather than saying that there is a 95% probability that the true value falls within the confidence interval. This information was taken from the *Washington State Department of Health - Assessment Guidelines* (or http://www.doh.wa.gov/data/guidelines/ConfIntguide.htm) website.

Medicaid Status: The source for the Medicaid designations used in PRAMS is the Washington State Department of Social and Health Services, First Steps Database. Medicaid women had either prenatal care or delivery paid by Medicaid. Medicaid women include those who are very low income and receive cash assistance (TANF) in addition to Medicaid (Grant Recipients) and those who receive Medicaid with no cash assistance (Other Medicaid).

Unintended pregnancy: This indicator is calculated from pregnancy indicators for Washington resident women (births and abortions) and the year 2000 estimated percentage of unintended births from the Washington State Pregnancy Risk Assessment Monitoring System (PRAMS).
Numerator: [%unintended from PRAMS data * (livebirths)] + abortions.
Denominator: livebirths + abortions.
In 2000, 38% (± 3%) of resident births were unintended, based on 1,565 PRAMS respondents, and a response rate of 81%. Birth, fetal death and abortion data are from the Washington State Center for Health Statistics 1999-2001.

Vital Statistics Definitions

For a complete list of vital statistics definitions, refer to *Washington State Department of Health-CHS* web page (or http://www.doh.wa.gov/EHSPHL/CHS/CHS-Data/main.htm). Technical notes are available for each of the data sources cited there.

Birth Weight: Weight of the fetus or infant at time of delivery (normally recorded in pounds and ounces).

Fetal Death: Death prior to the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy. The death is indicated by the fact that after such an expulsion or extraction the fetus does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles. Reporting of fetal deaths to the state is required only when the gestational period is twenty weeks or more.

Infant Death: Death of a child under one year of age (0-364 days).

Live Birth: The complete expulsion of extraction from its mother of a product of human conception, irrespective of the duration of pregnancy, which, after such expulsion or extraction, breathes, or show any other evidence of life such as beating of the heart,

pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached.

Neonatal: Death of an infant within the first 27 days of life.

Perinatal Death: Fetal deaths of 20 or more weeks' gestation plus infant deaths of less than seven days. This is one of four definitions used by the National Center for Health Statistics. Caution should be used in comparing perinatal death rates across reports unless it is certain that the same definition has been used.

Postneonatal Death: Death of infant of 28-364 days of age.

Appendix A: Technical Notes

Acronyms Used in MCH Data Report

AIAN	American Indian/Alaska Native
BSE	Bovine spongiform encephalopathy
BRFSS	Behavioral Risk Factor Surveillance System
CAHPS	Consumer Assessment of Health Plans Survey
CDC	Centers for Disease Control
CDR	Child Death Review
CHARS	Comprehensive Hospital Abstract Reporting System
CHIF	Child Health Intake Form
CI	Confidence Interval
CMHC	Community and Migrant Health Center(s)
CPS	Current Population Survey
CSHCN	Children with Special Health Care Needs
DPT	Diptheria, Pertussis, Tetanus
FPL	Federal Poverty Level
HP 2010	Healthy People 2010
HYS	Healthy Youth Survey
ICD-10	International Classification of Diseases - Version 10
ICD-9	International Classification of Diseases - Version 9
IMMENU	Immunization Menu software application
IMR	Infant Mortality Rate
LBW	Low Birth Weight (Less than 2500 grams)
LHJ	Local Health Jurisdiction
MAA	Medical Assistance Administration
MCH	Maternal and Child Health
MVI	Multi-Vitamins
NCHS	National Center for Health Statistics
NHOPI	Native Hawaiian, Other Pacific Islander
NIS	National Immunization Survey
NPM	National Performance Measure
OFM	Office of Financial Management
PRAMS	Pregnancy Risk Assessment Monitoring System
SCHIP	State Children's Health Insurance Program
SE	Standard Error
SIDS	Sudden Infant Death Syndrome
SLAITS	State and Local Area Integrated Telephone Survey
TANF	Temporary Assistance for Needy Families
UI	Unintentional Injury
VistaPHw	Statistical Software Package for Assessment
YRBS	Youth Risk Behavior Survey

Appendix B: Office of Maternal and Child Health Priority Needs 2000-2005

1. Improving access to comprehensive prenatal care.
2. Improving oral health status and access to oral health care services.
3. Improving the coordination of services for children with special health care needs.
4. Improving early identification, diagnosis and intervention services and coordination of services.
5. Decreasing family violence.
6. Decreasing unintended pregnancy and teenage pregnancy.
7. Improving mental health status.
8. Ensuring surveillance capacity for children with special health care needs.
9. Decreasing tobacco use.
10. Improving nutritional status.

Appendix C: State and National Performance Measures, MCH Block Grant

State Performance Measures

	Year	Rate
SP 1. The percent of pregnancies (live births, fetal deaths, abortions) that are unintended.	2000	53
SP 2. The percent of pregnant women abstaining from smoking.	2001	88
SP 3. The percent of women who receive counseling from their prenatal health care provider on tests for identifying birth defects or genetic disease.	2001	88
SP 4. Establish a sustainable strategy for assessing the prevalence of children with special health care needs		Process Measure
SP 5. The rate of youth using tobacco products	2002	9.2
SP 6. The percent of women who are screened for domestic violence during their prenatal care visits.	2001	49
SP 7. Increase the capacity of OMCH to assess mental health needs of the child and adolescent population and to promote early identification, prevention and intervention services.		Process Measure
SP 8. The percent of women who are screened during prenatal care visits for smoking, alcohol use, illegal drug use, HIV status, and postpartum birth control plans.	2001	60
SP 9. Develop and implement a set of measurable indicators and a strategic plan to improve nutrition status among the MCH population, initially focusing on food security; that is, absence of skipped meals or hunger due to lack of food.		Process Measure
SP 10. Increase statewide system capacity to promote health and safety in child care. SP 11. Increase to 100% the number of Local Health Jurisdictions with dedicated staff time providing public health consultation regarding health and safety in child care programs.		Process Measure

Appendix C: National Performance Measures

	Year	Rate
Percent of newborns in the State screened for conditions mandated by their State-sponsored newborn screening programs (e.g. PKU and hemoglobinopathies) and receive appropriate follow-up care as defined by their State	2001	93.6
The percent of children with special health care needs age 0 to 18 whose families partner in decision-making at all levels and are satisfied with the services they receive	2001	54.9
The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home.	2001	53.6
The percent of children with special health care needs whose families have adequate private and/or public insurance to pay for the services they need.	2001	64.4
The percent of children with special health care needs age 0 to 18 whose families report the community-based service system are organized so they can use them easily.	2001	74.1
The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life.	2001	5.8
Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertusis, haemophilus Influenza, Hepatitis B.	2001	71.2
The birth rate (per 1,000) for teenagers ages 15 through 17 years.	2001	17.7
Percent of third grade children who have received protective sealants on at least one permanent molar tooth.	2001	55.5
The rate of deaths to children ages 1-14 caused by motor vehicle crashes per 100,000 children.	2001	2.8
Percentage of mothers who breastfeed their infants at hospital discharge.	2001	87
Percentage of newborns that have been screened for hearing impairment before hospital discharge.	2002	62.2
Percent of children without health insurance.	2002	8.6
Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.	2001	67.4
Percent of very low birth weight live births.	2001	1.0
The rate (per 100,000) of suicide deaths among youths 15-19.	2001	8.1
Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.	2001	75.4
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.	2001	83.4

Appendix C: Federal Outcome Measures, MCH Block Grant

	Year	Rate
1. The infant mortality rate per 1,000 live births.	2001	5.8
2. The ratio of the black infant mortality rate to the white infant mortality rate.	2001	2.1
3. The neonatal mortality rate per 1,000 live births.	2001	3.7
4. The postneonatal mortality rate per 1,000 live births	2001	2.1
5. The perinatal mortality rate per 1,000 live births	2001	8.2
6. The child death rate per 100,000 for children ages 1-14	2001	17.9